

FILED DEC 17 1947

Registration District No. 280

Primary Registration District No. 5727

Registrar's No. 255

1. PLACE OF DEATH:

(a) County Macon Rural Morrow Twp
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon
(c) City or town Rural Morrow twp.
(If outside city or town limits, write "RURAL")
(d) Street No. Callao Mo R.F.D.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Barbara Ann Britt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Paul Britt 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 24 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>16</u>	hr. min.

9. Birthplace Macon Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {
12. Name Jacob Gibson
13. Birthplace Springfield, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Savanah Harris
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tensie Phipps
(b) Address Callao, Mo. R.F.D. #1
17. (a) Burial (b) Date thereof 11/14/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation College Mound, Mo.

18. (a) Signature of funeral director Albert Skuerner
(b) Address Macon Mo
19. (a) 12/8/47 (b) W. McNeely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10
year 1947 hour 11 minute _____ A.M.

21. I hereby certify that I attended the deceased from Nov 24, 1947 to Nov 10, 1947
that I last saw her alive on Nov 10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Due to Acute Septicemia 6 mos.

Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: 108
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury 3
23. Signature R.D. Measor (M.D. or other) _____
Address Macon Mo Date signed 4/13/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District File Officer No. 10
District File Number 12-47-1748
Date Filed DEC. 15. 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by
Howard F. Myers Registered Apprentice No. 468
working under my personal supervision.

Signed Albert Skinner
Licensed Embalmer No. 751
P. O. Address Macomb

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.