

FILED JAN 17 1948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44185

State File No. _____

Registration District No. 61

Primary Registration District No. 4707-4107

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town El Dorado Spgs, Mo.
(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

3. (a) PRINT FULL NAME Francis Marion Mayberry
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 26 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 29 hr. min.

9. Birthplace Ft. Scott, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Retired grain buyer

11. Industry or business _____

MOTHER FATHER { 12. Name Henry M. Mayberry
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Fairweather
15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Floyd Rogers
(b) Address Wichita, Kansas

17. (a) burial (b) Date thereof Nov. 26, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harwood Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Harwood, Missouri

19. (a) 11-26-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cedar,
(c) City or town El Dorado Spgs Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 25
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Death from natural cause

Due to Probably Heart Block

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations [Signature]
Of autopsy _____

Duration
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 _____

23. Signature [Signature] (M. D. or other)
Address El Dorado Springs, Mo. Date signed 11/26/47

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

RECEIVED
District Health Officer No. 7,
District File Number 12-42-3012
Date Filed 1-15-47

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Oliver Perry*

Licensed Embalmer No. 2709

P. O. Address Harwood, Missouri

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, above space should be left blank.

Registration District No. 61 Primary Registration District No. 407

1. PLACE OF DEATH:
(a) County Cedar
(b) City or town El Dorado Springs
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Francis M. Mayberry
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb 24 1884
(Month) (Day) (Year)

8. AGE: 79 Years 8 Months 2 Days (Unless than one day) _____ min.

9. Birthplace _____ (City, town, or county) Kansas (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute 10 A.M.
21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____
23. Signature M. D. Swann (M. D. or other) Prorer
Address El Dorado Springs, Mo. Date signed 11/25/47

SUPPLEMENTARY

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

MOTHER FATHER

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

44185