

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1609

FILED FEB 11 1948

Registration District No. 109

Primary Registration District No. 5614

Registrar's No. 199

1. PLACE OF DEATH:

(a) County Knox County.
(b) City or town Rural. Bourbon.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

Mary Ellen Ahern

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex ♀ 5. Color or race W. 6. (a) ~~Single~~, married, discussed
(b) Name of husband or wife Will B. Ahern 6. (c) Age of husband or wife if alive 86 years
7. Birth date of deceased Aug 16 1871 (Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Plerena Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name William C. Brancie
13. Birthplace not known North Carolina (City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Brancie
15. Birthplace not known Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Will B. Ahern
(b) Address Shelbyville Mo.

17. (a) _____ (b) Date thereof Jan. 27-48 (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Prairie

18. (a) Signature of funeral director W. Murphy

(b) Address Bethel, Mo.

19. (a) Feb-2-48 (b) Will B. Ahern (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Knox 52
(c) City or town Rural 2 1/2 mi S.E. of Plerena (If outside city or town limits, write "RURAL")
(d) Street No. 2 1/2 mi S.E. of Plerena (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 26 year 1948 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan 21 to Jan 25 1948
that I last saw him alive on Jan 25 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
hypertension
Due to hypertension
Due to hypertension
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 injury)
(c) Means of injury _____

23. Signature W. Murphy (M. D. or other) W. Murphy
Address Shelbyville Mo. Date signed Jan 31 1948

PHYSICIAN

Underline the cause to which death should be charged statistically.

106 1 8 48

RECEIVED
DISTRICT BOARD OF HEALTH NO.
2-48-2
FEB 10 1948
Date Filed

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 Brown

Licensed Embalmer No. 2749

P. O. Address Bethel, Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 199

Registration District No. 169

Primary Registration District No. 5614

1. PLACE OF DEATH:

(a) County Knox County
(b) City or town Rural
(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

Mary Ellen Ahern
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.
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business Housewife

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Neil S. Kline (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 Feb day 1 year 1948 hour 10 minute 15 M.
21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on 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?

(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other) Address Date signed

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

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

SUPPLEMENTARY

S-1609