

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7715**

FILED APR 8 1948

Registration District No. _____

Primary Registration District No. **3001**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **AUDRAIN.**
(b) City or town **LANDRIA. MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BROWN-REST-HOME. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 WEEKS.**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **MARY-ELIZABETH-BABB**

3. (b) If veteran, name war **CIVIL WAR** 3. (c) Social Security **PENSIONER CAR. NONE.**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **PETER-BABB** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JUNE-21-1866**
(Month) (Day) (Year)

8. AGE: Years **81** Months **9** Days **3** If less than one day hr. _____ min. _____

9. Birthplace **AUDRAIN CO. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWORK.**

11. Industry or business **HOME.**

MOTHER FATHER { 12. Name **H. B. KOCHLING.**
13. Birthplace **AUDRAIN-CO. MO.**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **UNKNOWN.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. Babb.**
(b) Address **CENTER-MO.**

17. (a) **BURIAL** (b) Date thereof **3/27/48.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **UNION-CHAPEL.**

18. (a) Signature of funeral director **Couch & Willey**

(b) Address **CENTER-MO.**

19. (a) **April 2 1948** (b) **Mallie Eugene**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ROLLS.**
(c) City or town **CENTER-MO.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **NO.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **25th**
year **1948** hour **1:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **MAR 15** 19**48** to **MAR 24** 19**48**
that I last saw her alive on **MAR 24** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia** 10 day

Due to **Influenza**

Due to _____

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

Major findings: Of operations _____

Of autopsy **330**

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) (e) Means of injury **11**

23. Signature **M. B. Babb** (M. D. or other) **DO.**

Address **LANDRIA-MO** Date signed **3/27/48**

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

RECEIVED
District Health Officer No. 1
District File Number 448-610
Date Filed APR -7 1948

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

John F. Ellis, Registered Apprentice No. 494
working under my personal supervision.

Signed Clyde W. Wicker
Licensed Embalmer No. 3826
P. O. Address Perry, 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.