

FILED MAY 1 1948

Registration District No. **2**

Primary Registration District No. **4009**

Registrar's No. **240**

1. PLACE OF DEATH:
 (a) County **Andrew**
 (b) City or town **Savannah Mo**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Michael Smitheran
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **23 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** County **Andrew** **999**
 (c) City or town **Covey** **10**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **10** (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **KATIE ADELA DIX**
 3. (b) If veteran, name war **No** 3. (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **23** year **1948** hour **11** minute **am**
 21. I hereby certify that I attended the deceased from **March 25** 19**48** to **April 23** 19**48** that I last saw him alive on **April 23** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive **79** years
 7. Birth date of deceased: **Nov 6 1869**
 (Month) (Day) (Year)

Immediate cause of death **Asperstatitis**
Pneumonia following removal of right breast-glands in axilla.
 Due to **also mitral regurgitation**
 Other conditions (Include pregnancy within 3 months of death) **50**

8. AGE: Years **77** Months **5** Days **17** If less than one day

Major findings: **Carcinoma of right breast and enlarged gland in axilla**
 Of operations.....
 Of autopsy.....

9. Birthplace: **Swelles Utah**
 (City, town, or county) (State or foreign country)

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) **0**
 While at work? (e) Means of injury.....
 23. Signature **J. J. Manning M. D.** Address **Savannah Mo** Date signed **4/23/48**

10. Usual occupation **Swelles Utah**
 11. Industry or business **Housewife**

12. Name **Hiram Phipper**
 13. Birthplace **Whitman Ill**
 (City, town, or county) (State or foreign country)

14. Maiden name **Mary Orye**
 15. Birthplace **Switzerland England**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Russ Gird**
 (b) Address **Covey Idaho**

17. (a) **Removal** (b) Date thereof **4/23-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Covey Idaho**

18. (a) Signature of funeral director **Marion Altman**
 (b) Address **Savannah Mo**
 19. (a) **April 23, 1948** (b) **Lillian Sparks**
 (Date received local registrar) (Registrar's signature)

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

MOTHER PARTER

PHYSICIAN
 Underline the cause of which death should be charged statistically.

DEC 27 1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *J. M. [Signature]*

Licensed Embalmer No. 2279

P. O. Address *[Handwritten Address]*

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.