

No. 2  
1/47  
5-17-39

FILED APR 26 1948

Registration District No. **3048**

1. PLACE OF DEATH:

(a) County: **RODAWAY**  
(b) City or town: **MARYVILLE**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **ST. ANNES**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: **5 WEEKS**  
(Specify whether In this community: **5 WEEKS**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **MISSOURI** (b) County: **Andrew**  
(c) City or town: **NEAR ROCHESTER 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: .....

3. (a) PRINT FULL NAME: **Mabel Mattiemay Shanks**

3. (b) If veteran, name war: **L** 3. (c) Social Security No.: **L**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **7**  
year **1948** hour **8** minute **0** M.

21. I hereby certify that I attended the deceased from **Oct 8**  
....., 19**47** to **April 7**, 19**48**  
that I last saw **her** alive on **April 6**, 19**48**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Breits disease** Duration: **2 1/2 yr +**

4. Sex: **F** 5. Color or race: **W** 6. (a) Single, widowed, married: **m**  
6. (b) Name of husband or wife: **DAVID SHANKS** 6. (c) Age of husband or wife if alive: **70** years  
7. Birth date of deceased: **OCT 13 - 1899**  
(Month) (Day) (Year)

8. AGE: Years **49** Months **5** Days **24** If less than one day  
.....hr. ....min.

9. Birthplace: **MILTONVILLE MISSOURI**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **AT HOME**

11. Industry or business: .....

12. Name: **MAXION MERRIT FRELOVE**

13. Birthplace: **PIEDMONT ROCK NEB**  
(City, town, or county) (State or foreign country)

14. Maiden name: **MARY ANN HAZZLET**

15. Birthplace: **JAMESVILLE MISSOURI**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **David Shanks**  
(b) Address: **ROCHESTER MO**

17. (a) **Burial** (b) Date thereof: **4-9-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Helena MO**

18. (a) Signature of general director: **E. C. Breit**  
(b) Address: **Savannah MO**  
19. (a) **4-14-48** (b) **Bess Holt**  
(Date received local registrar) (Registrar's signature)

Due to: .....

Due to: .....

Other conditions: **=**  
(Include pregnancy within 3 months of death)

Major findings: **1318**  
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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **0**

White at work? .....

23. Signature: **William B. Kelly** (M. D. or other) **MD**  
Address: **Savannah MO** Date signed: **4-9-48**

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

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

MOTHER FATHER

**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 E. C. Breit  
Licensed Embalmer No. 2630  
P. O. Address Savannah 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.

Registration District No. 251

Primary Registration District No. 3048

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

1. PLACE OF DEATH:

(a) County Nodaway  
(b) City or town Marionville  
(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 Mabel M. Shurba

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

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

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

7. Birth date of deceased Oct 13 (Month) (Day) (Year)

8. AGE: Years 49 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify type of place)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 4-14-48 (b) Beas Holt (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 CERTIFICATE FROM

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1948 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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) (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.

SUPPLEMENTARY

S-13497