S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 12 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

19335

State File No.

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 14

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(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 64 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Howell
(c) City or town West Plains 46
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 3. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country 0

3. (a) PRINT FULL NAME Mary E. Romans
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex F1
5. Color or race W.
6. (a) Single, widowed, married, divorced M 1
6. (b) Name of husband or wife J.W. Romans
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 30 - 1867
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 29 If less than one day hr. min.

9. Birthplace Scott Co. Va. 1
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Abner Papp
13. Birthplace N. Carolina 1
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Nancy McConnell
15. Birthplace N. Carolina 1
(City, town, or county) (State or foreign country)
16. (a) Informant J.W. Romans
(b) Address West Plains MO
17. (a) B (b) Date thereof 5/31-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cornell
18. (a) Signature of funeral director Robertsons
(b) Address West Plains, MO
19. (a) July 1-48 (b) Beatrice Cook 379
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 29
year 48 hour 3 minute 20 A M.

21. I hereby certify that I attended the deceased from May 24, 1948, to May 29, 1948; that I last saw her alive on May 26, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia, left side, 2nd attack
Due to Cerebral Haemorrhage
Due to Arteriosclerosis
Other conditions Bronchial pneumonia relieved before she died
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —
830

Duration

PHYSICIAN
Underline the cause of 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 A.H. Thornburgh (M. D. or other) M.D.
Address West Plains, Mo. Date signed 6/2/48
Thornburgh

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED 7-6-48
District Health Officer No. 5,
District File Number 748432
Date Filed 7-6-48

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 Robert T. Drago Registered Apprentice No. 432 working under my personal supervision.

Signed D D Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.