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1948

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

49  
FEB 1948  
Registration District No. \_\_\_\_\_

3028  
Primary Registration District No. \_\_\_\_\_

149  
Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County..... **Jasper**

(b) City or town..... **Carthage**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution..... **133 South Main St.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **No**  
(Specify whether

In this community..... **83 Years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **Jasper**

(c) City or town..... **Carthage**  
(If outside city or town limits, write "RURAL")

(d) Street No..... **133 South Main St.**  
(If rural, give location)

(e) Citizen of foreign country?..... **No** (Yes or No)

If yes, name country..... **None**

3. (a) PRINT FULL NAME..... **Mary Jane MEARES**

3. (b) If veteran, name war..... **No**

3. (c) Social Security No. .... **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **June** day..... **20th.**  
year..... **1948** hour..... **2:40** minute..... **P.**

4. Sex..... **Female**

5. Color or race..... **White**

6. (a) Single, widowed, married, divorced..... **Widowed**

6. (b) Name of husband or wife..... **James Madison Meares**

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... **October 12, 1859**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from.....  
**June 11**....., 19**48** to..... **June 20**....., 19**48**;  
that I last saw her alive on..... **June 19**....., 19**48**  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>88</b>	<b>8</b>	<b>8</b>	.....hr. ....min.

Immediate cause of death.....  
**Cerebral hemorrhage**

9. Birthplace..... **Unknown Ill.**  
(City, town, or county) (State or foreign country)

Due to.....

Due to.....

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

10. Usual occupation..... **Housewife**

Major findings:  
Of operations.....

11. Industry or business..... **None**

Of autopsy..... **430**

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

12. Name..... **David Busby**

13. Birthplace..... **Unknown Ill.**  
(City, town, or county) (State or foreign country)

14. Maiden name..... **Mary Roland**

15. Birthplace..... **Unknown Ill.**  
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mr. Leonard Meares**

(b) Address..... **Carthage, Mo.**

17. (a) **Burial** (b) Date thereof..... **6-22-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Dudman Cemetery**

18. (a) Signature of funeral director..... **Ed. C. Ulmer**

(b) Address..... **Carthage, Mo.**

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..... **John B. Chilton** (M. D. or other)

Address..... **Carthage, Mo.** Date..... **June 4, 48**

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

MOTHER FATHER

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 \_\_\_\_\_

*Marion Y. McCormick*

Registered Apprentice No. 17

working under my personal supervision. Marion Y. McCormick

*Gene C. Pugh*

Signed \_\_\_\_\_  
Gene. C. Pugh.

Licensed Embalmer No. 4231

P. O. Address Carthage, 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. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carthage  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Mary J. Meares  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month July Day 20  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 12 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years 88 Months 8 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Major findings: Of operations \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

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)

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 \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) 6-21-48 (b) Belinton  
(Date received local registrar) (Registrar's signature)

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

**SUPPLEMENTARY**

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

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

S-19814