

FILED JUL 12 1948

Registration District No. **294**

Primary Registration District No. **4547**

Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **Worth**
(b) City or town **Grant City**
(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 **10 days** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Worth** **113**
(c) City or town **Sheridan** **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Margaret Virginia Wake**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Frederick Thomas Wake** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 13** **1866**
(Month) (Day) (Year)

8. AGE: Years **82** Months **3** Days **14** If less than one day
hr. min.

9. Birthplace **Union County Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Albert Lemon**
13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Ann Lamar**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sherman Wake**
(b) Address **Sheridan, Mo.**

17. (a) **Burial** (b) Date thereof **6-29-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Isadora Cemetery**

18. (c) Signature of funeral director **Arch C. Duffee**
(b) Address **Grant City, Mo.**

19. (a) **July 48** (b) **John E. Duverson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **27**
year **1948** hour **7** minute **00 AM**

21. I hereby certify that I attended the deceased from **6-20-48** to **6-27-48** 19 **48**
that I last saw her alive on **6-27-48** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **stroke - degeneration of heart**
Due to _____
Due to _____

Other conditions **hypertension**
(Include pregnancy within a year of death) **3 yrs**

Major findings: Of operations _____ Of autopsy **no**
PHYSICIAN _____
Underline the cause to 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? **✓**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. H. ...** (M. D. or other) _____
Address **Grant City, Mo.** Date signed **6-27-48**

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

2
43
39
335697

DISTRICT HEALTH OFFICE
Camden, 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 *Arch C. Duffee*

Licensed Embalmer No. *3252*

P. O. 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.