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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 6 1948
Registration District No. 137

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

State File No. 23275

Registrar's No. 173

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: 210 E. Chestnut St. / (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days): In this community: 80 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jasper 49 / 3
(c) City or town: Carthage (If outside city or town limits, write "RURAL") 0
(d) Street No.: 210 E. Chestnut St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: MARY JANE OLIVER
3. (b) If veteran, name war: none
3. (c) Social Security No.: none
4. Sex: female /
5. Color or race: white
6. (a) Single, widowed, married, divorced: 2 widowed
6. (b) Name of husband or wife: unknown
6. (c) Age of husband or wife if alive: --- years
7. Birth date of deceased: unknown (Month) 1858 (Day) (Year)

8. AGE: Years 90 | Months ? | Days ? | If less than one day ___ hr. ___ min.

9. Birthplace: unknown (City, town, or county) unknown 9 (State or foreign country)
10. Usual occupation: at home
11. Industry or business: ----

MOTHER FATHER
12. Name: unknown 9
13. Birthplace: unknown (City, town, or county) (State or foreign country)
14. Maiden name: unknown 9
15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Knell Mortuary
(b) Address: Carthage, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: July 23, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Park Cemetery
18. (a) Signature of funeral director: Knell Mortuary
(b) Address: Carthage, Mo.
19. (a) 7-24-1948 (Date received local registrar) (b) E. B. Clayton M.D. (Registrar's signature) By H.
137
0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1948 hour 5:30 minute P. M.
21. I hereby certify that I attended the deceased from ____, 19__; Did Not Attend; that I last saw him alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic	
Due to: Myocarditis	
Due to: Senility	
Other conditions (Include pregnancy within 3 months of death): 9	
Major findings: Of operations: 9	
Of autopsy: 9	

Leonard Frank M.D.

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? (Specify type of place)
While at work?
(e) Means of injury
(f) Signature L. W. Frank M.D. (M. D. or other)
Address 214 Joplin Date signed 7-26-48

(Licensed Embalmer's Statement on Reverse Side)

48-7-651

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 Emma R Kney

Licensed Embalmer No. 391

P. O. Address Carthage - M

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.