

FILED SEP 20 1948

Registration District No. **86**

Primary Registration District No. **5322**

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

1. PLACE OF DEATH:

(a) County **CANFORD**  
(b) City or town **Canford, Mo**  
(c) Name of hospital or institution **3 Mi. So. of Canford, Mo**  
(d) Length of stay: In hospital or institution **4 years**  
In this community **4 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **MAYES**  
(c) City or town **Metz**  
(d) Street No. **TR. R. #1**  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **MARFHA ENDLETON**

3. (b) If veteran, name war  3. (c) Social Security No. **2**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W 2**  
6. (b) Name of husband or wife **HENRY** 6. (c) Age of husband or wife if alive **21** years  
7. Birth date of deceased **3 21 1862**

8. AGE: Years **86** Months **5** Days **19** If less than one day hr. min.

9. Birthplace **DIXON Mo. U.S.A.**

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **AMOS ROBERTS**  
13. Birthplace **VA. U.S.A.**  
14. Maiden name **UNK**  
15. Birthplace **UNK U.S.A.**

16. (a) Informant **DATA T. 12**

(b) Address **Canford, Mo**  
17. (a) **BURIAL** (b) Date thereof **9-11-48**

(c) Place: burial or cremation **States Cem., Metz, Mo**  
18. (a) Signature of funeral director **H.H. Strat.**

(b) Address **Metz, Mo**  
19. (a) **9-9-48** (b) **Anna A. Strat.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **9**  
year **1948** hour **12** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **Aug 24**, 19**48**, to **Sept 9**, 19**48**.  
that I last saw her alive on **Aug 24**, 19**48**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acidosis**  
Due to **Diabetes Mellitus** **4** yrs.

Due to \_\_\_\_\_  
Other conditions **Degenerative Heart disease, & hypertensive encephalopathy**

Major findings: **61**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 **0**  
23. Signature **H. H. Strat.** (M. D. or other) **md**  
Address **Canford, Mo** Date signed **9-9-48**

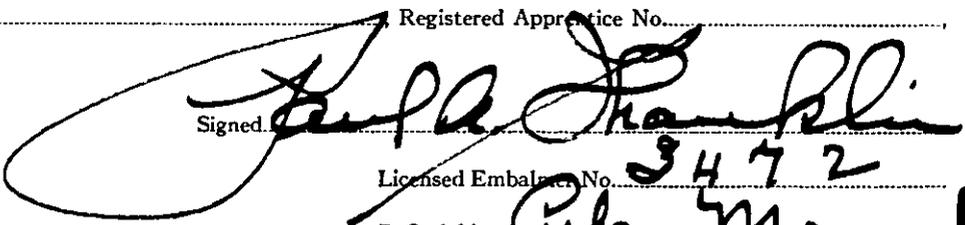
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECORDED 9-13-48  
District Health Officer No. 5,  
District File Number 948567  
Date Filed 9-13-48

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.....

..... Registered Apprentice No. ....  
working under my personal supervision.

Signed   
Licensed Embalmer No. 3472  
P. O. Address Cuba, 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.