S. No. 300
M—10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 20 1948

Registration District No. 1933

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4301

State File No. 30319

Registrar's No. 23

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

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Meadville
(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 years, months or days)
In this community 80 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Meadville
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME MARGARET ANN DENNIS

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 John Dennis

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

7. Birth date of deceased February (Month) 28 (Day) 1857 (Year)

8. AGE: Years 91 Months 6 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace Genoia, Iowa (City, town, or county) / (State or foreign country)

10. Usual occupation At Home

11. Industry or business ____

FATHER
12. Name Joseph Wells
13. Birthplace Carlile, Indiana (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Katherine Kerns
15. Birthplace Carlile, Indiana (City, town, or county) / (State or foreign country)

16. (a) Informant Mrs. Opal Williams
(b) Address Chillicothe, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (Month) (Day) (Year)
(c) Place: burial or cremation Meadville Cemetery

18. (a) Signature of funeral director Norman Funeral Home
(b) Address Chillicothe, Missouri.

19. (a) Sept. 7-1948 (Date received local registrar) (b) Chris A. Martenez (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 5 year 1948 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from 7-16-48, 19__, to 9-5, 1948; that I last saw her alive on 9-5, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial failure	
Due to: Hypertension	
Due to: Chronic nephritis	
Due to: senility	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature S. H. Hanson (M. D. or other) DO
Address Meadville Mo Date signed 9-6-48

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, 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 Edwin F. Norman.

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

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.