

No. 2  
1-5-43  
5-17-39  
I X35871

FILED SEP 27 1948

Registration District No. **556**

Primary Registration District No. **6209**

Registrar's No. **39**

1. PLACE OF DEATH:

(a) County **TEXAS**

(b) City or town **RURAL PINEY**  
(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 years, months or days) **4 YRS.**

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **TEXAS**

(c) City or town **CABOOL**  
(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 **MATTIE E. DULL**

3. (b) If veteran, name war **L**

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT.** day **14**  
year **1948** hour **6** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Aug 20** 19 **8** to **Sept 12** 19 **48**  
that I last saw her alive on **Sept 12** 19 **48**  
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **W**

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

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

7. Birth date of deceased **DEC. 11 1866**  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

**acute heart failure**

Due to **hypertension**

Due to **arteriosclerotic heart disease**

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

8. AGE: Years Months Days If less than one day

<b>81</b>	<b>9</b>	<b>5</b>	hr. min.
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PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

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

10. Usual occupation **HOUSE WIFE**

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? \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **WILLIAM AMBURN**

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

14. Maiden name **WESCOOT**

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury **0**

23. Signature **J. J. Burns** (M. D. or other) \_\_\_\_\_  
Address **Houston, Mo.** Date signed **Sept. 16, 48**

16. (a) Informant **MRS. ARCHIE TOTTEN**

(b) Address **HOUSTON, MO**

17. (a) **BURIAL** (b) Date thereof **9-16-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CABOOL**

18. (a) Signature of funeral director **Hayward U. Elliott**

(b) Address **HOUSTON, MO**

19. (a) **Sept. 17, 48** (b) **Myrtle Craig**  
(Date received local registrar) (Registrar's signature) **387**

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

7  
8

RECEIVED 9-20-48  
District Health Officer No. 5,  
District File Number 248615  
Date Filed 9-22-48

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.....

.....  
working under my personal supervision.

.....  
Registered Apprentice No. ....

Signed Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, Tex.

**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.**