

FILED JUN 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18505

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 185

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkville, Mo.	
c. LENGTH OF STAY (in this place) 2 Mon			
d. FULL NAME OF HOSPITAL OR INSTITUTION 141 S. Osteopathy		d. STREET ADDRESS (If rural, give location) 414 S. Osteopathy	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Cory c. (Last) Mahurin			4. DATE OF DEATH (Month) (Day) (Year) 6/22/49			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11/17/1869	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Peoria, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Walter McMaster		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Ashbury Mahurin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS M. C. Cory, Kirkville, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Accident		DUE TO (b) Coronary Thrombosis			15 min	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Diabetes Mellitus			1 yr.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					15 yrs	
					260X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July 9, 1948, to June 22, 1949, that I last saw the deceased alive on June 8, 1949, and that death occurred at 5:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John E. Wilkinson D.O.		23b. ADDRESS Kirkville, Mo.		23c. DATE SIGNED 6-23-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/24/49		24c. NAME OF CEMETERY OR CREMATORY Greencastle	
				24d. LOCATION (City, town, or county) (State) Greencastle, Mo.	

DATE REC'D BY LOCAL REG. 6-24-49		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paul M. O'Leary, Kirkville, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No.

District File Number 2-49-108

Date Filed JUN 27 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Ray H. Merwin

Signed _____
Student Embalmer

Licensed Embalmer No. 4432

P. O. Address Kirkville, 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.