

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29039
44

State File No. _____

FILED SEP 9 1949

BIRTH NO. _____		REG. DIST. NO. <u>381</u>		PRIMARY REG. DIST. NO. <u>45-13</u> Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u>		c. LENGTH OF STAY (In this place) <u>24 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Simpson Hosp</u>			d. STREET ADDRESS (If rural, give location) <u>2 D</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mauey</u> b. (Middle) <u>Viola</u> c. (Last) <u>Marr</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8-25-1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	
8. DATE OF BIRTH <u>7-30-1886</u>		9. AGE (In years last birthday) <u>93</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Monroe Co. Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>James M Pollard</u>			
13b. MOTHER'S MAIDEN NAME <u>Mary Blackburn</u>		14. NAME OF HUSBAND OR WIFE <u>Orrel A Marr (dead)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>PM Marr</u> ADDRESS <u>Milan</u>	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senile changes.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>794X</u>			INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		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 <u>8-20</u> , 19 <u>49</u> , to <u>8-25</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-25</u> , 19 <u>49</u> , and that death occurred at <u>5:12</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>W Simpson</u> (Degree of title) _____		23b. ADDRESS <u>Milan, Mo.</u>		23c. DATE SIGNED <u>8-25-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/27/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u>	
24d. LOCATION (City, town, or county) <u>Paris, Mo.</u>		24e. (State) _____			
DATE REC'D BY LOCAL REG. <u>Aug. 31-1949</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u> <u>320</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Shoemaker</u> ADDRESS <u>Milan</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Handwritten notes and markings at the top left of the page, including the number '11' and other illegible scribbles.

RECEIVED
SEP 6
District Health Officer No. _____
District File Number 9-49-1
Date Filed SEP 6 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 D. Norris Cleton

Signed _____
Student Embalmer

Licensed Embalmer No. 4682

P. O. Address Milan, 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.