

STANDARD CERTIFICATE OF DEATH

State File No. **8390**

FILED MAR 2 - 1953

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **6093** Registrar's No. **53**

1970
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Marshall T.W.P.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Marshall T.W.P.	
c. LENGTH OF STAY (in this place) 17 yrs		d. STREET ADDRESS (If rural, give location) Saline County Home	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saline County Home			
3. NAME OF DECEASED (Type or Print) a. (First) GERTRUDE		b. (Middle) MARY	
c. (Last) FLANAGAN		4. DATE OF DEATH (Month) (Day) (Year) Feb. 23 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Aug. 24, 1883
9. AGE (In years) last birthday 69		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY County Home	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Thomas Flanagan	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Records Saline County Home Marshall Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Causes		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) L	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		_____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 4500	
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 Jan 1, 1953 , to Feb 23, 1953 that I last saw the deceased alive on Aug 20, 1953 and that death occurred at 3:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title) M.D.		23b. ADDRESS Marshall Mo	
23c. DATE SIGNED 2/24/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2-25, 1953		24c. NAME OF CEMETERY OR CREMATORY Saline County Home	
24d. LOCATION (City, town, or county) (State) Marshall Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harry Hershbarger Marshall, Mo.	
DATE REC'D BY LOCAL REG. 2-25-1953		REGISTRAR'S SIGNATURE [Signature]	

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.

Student
Student Embalmer

Signed Joseph R. Mackler

Licensed Embalmer No. 4571

P. O. Address Marshall, 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.