

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REG 1 DEC 15 1939
Registration District No. 13347

Primary Registration District No. 5485

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Monroe
(b) City or town Russell Springs Bogard Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 74 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 96 E of Quick
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Fannie Graham
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 1 year 1939 hour 6 minute 25 A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 4 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 5, 1939, to Nov 28, 1939; that I last saw him alive on Nov 28, 1939; and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 9 Days 27 If less than one day _____ hr. _____ min.

Immediate cause of death Acute Myocarditis Duration 30 days
Due to Chronic Arthritis 20 yrs.
Due to _____

9. Birthplace St Charles Co Mo
(City, town, or county) (State or foreign country)

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation Housewife

11. Industry or business _____
12. Name James Moore
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Clara Mason
15. Birthplace Wabersaw
(City, town, or county) (State or foreign country)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant's own signature Gertrude Wells
(b) Address Quick Mo

17. (a) burial (b) Date thereof 12-2-1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation North Cemetery

18. (a) Signature of funeral director Fred G. Wilkinson
(b) Address Clinton Mo

19. (a) 12-2-39 (b) W. J. R. Smith
(Date received local registrar) (Registrar's signature)

23. Signature J. S. McDonald (M. D. or other) _____
Address Quick Mo Date signed 12-2-39

RECEIVED

District Health Officer No. 7;

District File Number 12-39-105

Date Filed 12-12-39

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.