

State File No. _____

FILED MAR 20 1945
Registration District No. 221

Primary Registration District No. 5793

Registrar's No. _____

1. PLACE OF DEATH:

(a) County MONITEAU
(b) City or town LINN JUNG RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONITEAU
(c) City or town LINN (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARTHA F. CHILDRESS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE / Color or WHITE
5. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 6 (Month) 22 (Day) 1864 (Year)

8. AGE: Years 80 Months 7 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER

12. Name TAM CHILDRESS

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

14. Maiden name unknown

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

16. (a) Informant Lillian B. Brumbyrne

(b) Address Farmstown Mo.

17. (a) BURIAL (b) Date thereof 2-5-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion Cem.

18. (a) Signature of funeral director C. Albert Hornbeck

(b) Address Prairie Home Mo.

19. (a) Feb 6 - 1945 (b) Prarie Home Mo. (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 4
year 1945 hour 1 minute 30 A.
21. I hereby certify that I attended the deceased from 2 to 2-4-45
2 to 2-3-45
that I last saw him alive on 2-3 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Disease of Heart Duration 7

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: g d

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

23. Signature C. Albert Hornbeck M. D. or other _____

Address Prairie Home Mo. signed _____

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

68
00

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-19-45

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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.