S. No. -
M—5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24804

State File No.

Registration District No. 297 Primary Registration District No. 4447 Registrar's No. 50

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

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Henrietta
(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 Ray
(c) City or town Henrietta
(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 Mary Kathrine Listebarger
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clyde L. Listebarger
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased May. (Month) 7 (Day) 1896 (Year)

8. AGE: Years	Months	Days	If less than one day
49	2	26	hr. min.

9. Birthplace Richmond (City, town, or county) Mo. (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name Peter Kirk
13. Birthplace -------- (City, town, or county) Scotland (State or foreign country)
MOTHER
14. Maiden name Mary Jane Murray
15. Birthplace ------------- (City, town, or county) Irland (State or foreign country)
16. (a) Informant Clyde L. Listebarger
(b) Address Henrietta Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5. 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Richmond. Mo.
18. (a) Signature of funeral director E Brunnan
(b) Address Richmond. Mo.
19. (a) Aug 7 45 (Date received local registrar) (b) Mrs Chas W Sheppard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 2 year 1945 hour 10 minute 30. P. M.
21. I hereby certify that I attended the deceased from June 1, 1945 to Aug 2, 1945
that I last saw her alive on Aug 2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis | Duration
Due to Nephritis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(Specify type of place)
While at work (e) Means of injury
23. Signature E. E. Fay (M. D. or other)
Address Richmond Date signed 8-4-45

12-50

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8;
District File Number
Filed 8-13-45

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, ##

Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 2073

P. O. Address Richmond. 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.

S. No. 2B
5M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

AUG 14 1945

State File No. _____

Registration District No. 297 | Primary Registration District No. 4447 | Registrar's No. 50

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Henrietta
(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 years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary K Listebarger

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

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 7 1896
(Month) (Day) (Year)

8. AGE: Years 49 | Months 2 | Days _____ | If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER / FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER / FATHER
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic	
Due to _____	
Due to _____	
Other conditions _____ (Include pregnancy within 3 months of death)	
Major findings: 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 E. E. Richmond (M. D. or other)

Address _____ Date signed 8-17-45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED