

Registration District No. 677

Primary Registration District No. 4403

79

1. PLACE OF DEATH

(a) County Phelps
(b) City or town Reed
(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 & days)

3. (a) PRINT FULL NAME George Dewing 520

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

4. Sex m 5. Color or race wh 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Sept 5 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Karl Dewing

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

14. Maiden name _____

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

16. (a) Informant Mrs. Caroline Adams

(b) Address Reed, Mo

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof June 28, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Dewing Cemetery

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

19. (a) June 28, 1940 (b) Jan. F. Myers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town Reed
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1940 hour 11 minute 4 P. M.

21. I hereby certify that I attended the deceased from June 15, 1940, to June 27, 1940; that I last saw him alive on June 24, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Senility

Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

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. Fink, D (M. D. or other) _____
Address Reed, Mo Date signed July 9, 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.

District Health Officer No. 5,

District File Number 240 793

Date Filed 7 22 40

Signed S. L. [Signature]

Licensed Embalmer No. 3391

P. O. Address [Signature]

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.