

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29027

Registration District No. 142

Primary Registration District No. 5698

Registrar's No.

1. PLACE OF DEATH:
 (a) County McDonald
 (b) City or town Rural Buffalo, Mo
(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 7 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John Floyd Talley
 (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex Male
 5. Color or race White
 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 January 12-1908
(Month) (Day) (Year)

8. AGE: Years 32 Months 7 Days 12
 If less than one day hr. _____ min. _____

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

10. Usual occupation Soldier in U.S. Army

11. Industry or business _____

12. Name John H. Talley

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

14. Maiden name Ethel Sims

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

16. (a) Informant John H. Talley
 (b) Address Goodman mo

17. (a) Removal (b) Date thereof 8-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation My Chere Home

18. (a) Signature of funeral director Chas. W. Williams
 (b) Address Goodman mo

19. (a) 9-10-40 (b) Chas. W. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County McDonald
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Goodman mo (R.D. #1)
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 30
 year 1940 hour 07 minute 30 A.M.
 21. I hereby certify that I attended the deceased from _____
 _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death His organ Died
Very sudden there was
no doctor called
 Due to he died of heart disease
 Due to Signed Chas. Williams
Local Registrar
 Other conditions Dist No 142
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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?
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(Specify type of place) (e) Means of injury
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

RECEIVED
District Health Officer No. 6
District File Number 940-2683
Date Filed 1-2-1947

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.