

AN 25 1941 3 27

Registration District No. _____

Primary Registration District No. 4194

Registrar's No. 1

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

1. PLACE OF DEATH: Grundy
 (a) County Grundy
 (b) City or town Galt Mo
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
 In this community Life time
 years, months or days

3. (a) PRINT FULL NAME JAMES G. GERMAN
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex male
 5. Color or race Wht
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife Elizabeth
 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased Jan. 15-1850
 (Month) (Day) (Year)

8. AGE: Years 90 Months 11 Days 23
 If less than one day — hr. — min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER
 12. Name Ruth German
 13. Birthplace unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Adaline Hayden
 15. Birthplace Mo 1
 (City, town, or county) (State or foreign country)

16. (a) Informant Mo German
 (b) Address Galt Mo

17. (a) Galt Mo Cem (b) Date thereof Jan 8-1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Galt Mo

18. (a) Signature of funeral director P. Dayneson
 (b) Address Galt Mo

19. (a) 1-7-41 (b) W. C. Weston
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Grundy 40
 (c) City or town Galt
 (If outside city or town limits, write "RURAL")
 (d) Street No. —
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7
 year 1941 hour 4:50 minute 0 M.

21. I hereby certify that I attended the deceased from 11-30- 1940, to 1-7- 1941,
 that I last saw him alive on 1-6- 1941,
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy
 Due to Arterio Sclerosis

Due to _____
 Other conditions 73 W
 (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?
2 AM (Specify type of place)
 While at work? _____ (e) Means of injury _____
 28. Signature W. C. Weston (M. D. —)
 Address Galt, Mo Date signed 1-7-41

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.