

REG FEB 25 1941

Registration District No. 823

Primary Registration District No. 4497

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Sumner  
(c) Name of hospital or institution: 1  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 50 years  
years, months or days

3. (a) PRINT FULL NAME George R. Deakins

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased July 19 1860  
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Retired

12. Name Jim Deakins

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

14. Maiden name Angela E. Deakins

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

16. (a) Informant's own signature James Lee Deakins

(b) Address Sumner

17. (a) Burial (b) Date thereof 1/8/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sumner, Mo

18. (a) Signature of funeral director W. J. Leibel  
(b) Address W. J. Leibel

19. (a) 1-10-41 (b) Frank Hyde, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon

(c) City or town Sumner  
(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 1 day 6  
year 41 hour \_\_\_\_\_ minute 10

21. I hereby certify that I attended the deceased from Jan 1, 1941, to Jan 6, 1941;  
that I last saw him alive on Jan 4, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration \_\_\_\_\_

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 Frank Hyde (M. D. or other) \_\_\_\_\_

Address Sumner, Mo Date signed 1-6-41

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM 1 1931

RECEIVED

District Health Officer No. 5,

District File Number 24/280

Date Filed \_\_\_\_\_

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 1/7/41

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address Way Cross

**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.**