

FILED MAR 19 1941

Registration District No. 5716

Primary Registration District No. 5735

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Sage Rural  
(c) Name of hospital or institution: 1  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps  
(c) City or town Sage (Rural)  
(d) Street No. 0  
(e) If foreign born, how long in U. S. A. 1 years.

3. (a) PRINT FULL NAME Chas. E. Sholson

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

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

6. (b) Name of husband or wife Lois Sholson 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased 12-11-1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 2 Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Salesman

11. Industry or business

12. Name Alfred Sholson  
13. Birthplace \_\_\_\_\_  
14. Maiden name Amanda Griffin  
15. Birthplace \_\_\_\_\_

16. (a) Informant Lois Sholson

(b) Address Sage Mo

17. (a) Burial (b) Date thereof 3-9-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Gate Cem

18. (a) Signature of funeral director W E Kucklender

(b) Address St James Mo

19. (a) Mar-18-1941 (b) Sage a Warner  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 5  
year 1941 hour 3:40 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 1938, 19\_\_\_\_, to March 5 - 1941, that I last saw him alive on March 4 - 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Pneumonia (Bronchial Type) Duration 3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) Had Bronchial asthma for a number of years

Major findings Of operations \_\_\_\_\_

Of autopsy no

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? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

4 \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature William H. Brown (M. D. or other) \_\_\_\_\_

Address St James Mo Date signed 3/6/41

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

003

**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.....

*me*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Oral E Licklider*

Licensed Embalmer No. *3544*

P. O. Address *St James*

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.