

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.

FILED APR 9 1941

Registration District No. **51**

Primary Registration District No. **4050**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Bates
 (b) City or town Hume
 (If outside city or town limits, write "RURAL" and name of township)
 (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)
 In this community natural life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Bates
 (c) City or town Hume
 (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.? 0 years.

3. (a) PRINT FULL NAME William Silas Flanery

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

4. Sex m 5. Color or race w. 6. (a) Single, widowed, married, divorced M.
 6. (b) Name of husband or wife Ethel M. 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased Oct 6 1885
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>55</u>	<u>3</u>	<u>4</u>	<u>29</u>	hr. _____ min. _____

9. Birthplace Vernon (City, town, or county) no (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name J. S. Flanery

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

14. Maiden name Margaret Hall

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

16. (a) Informant's own signature Ethel M. Flanery

(b) Address Hume Mo.

17. (a) Burial (b) Date thereof 3 7 41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hume

18. (a) Signature of funeral director Booth

(b) Address Rich Hill

19. (a) 9-1941 (b) Frank Martin
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
 year 1941 hour 5:40 minute _____ P. M.

21. I hereby certify that I attended the deceased from 2/5/41, 1941, to 3/2/41, 1941;
 that I last saw him alive on 2/5/41, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 3/2/41 to 3/5/41

Due to Effusion while working at the mill, come down!

Due to both these going into pneumonia

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 _____

(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? 54

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. L. Hodges (M. D. or other) MD

Address Beth, Mo. Date signed 3/8/41

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 4-41-609

Date Filed 4-7-41

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

John J. Underwood

Licensed Embalmer No. 3585

P. O. Address Butler Mo

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.

Registration District No. 51

Primary Registration District No. 4030

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Home
(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 or days)

3. (a) PRINT FULL NAME Wm. Silas Flanery

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

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

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

7. Birth date of deceased Oct 6 1885
(Month) (Day) (Year)

8. AGE: Years 55 ~~54~~ Months 4 Days 29
If less than one day, hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 9 (b) Jern H Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 5
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia 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 Dr. K. L. Nielsen (M. D. or other) _____

Address Butler mo Date signed _____

SUPPLEMENTARY

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

S-9980 1941

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, fact should be so stated above.