

FILED JUN 22 1942

Registration District No. _____

Primary Registration District No. 44-5
540-2

Registrar's No. _____

1. PLACE OF DEATH

(a) County Phelps
(b) City or town St James
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Phelps Home #
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 15 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town St James
(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 May day 29
year 42 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from on
May 28 1942 at present
that I last saw him alive on May 28 1942
and that death occurred on the date and hour stated above
Immediate cause of death: Edema of
face

Duration

Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underlines
the cause to
which death
should be
charged sta-
tistically.

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 C. H. Fulbright (M. D. or other) _____
Address St James Mo Date signed 5-29

3. (a) PRINT FULL NAME John George

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

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

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

7. Birth date of deceased Don't know (Month) (Day) (Year)

8. AGE: Years 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Don't know (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER { 12. Name _____ 9
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ 9
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation Matthews Cemetery

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-29-42 (b) Chas. W. Dickerson (Date received local registrar) (Registrar's signature)

1011

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

81
30

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.