

FILED JUL 22 1943

Registration District No. 270

Primary Registration District No. 5769

Registrar's No. 136

1. PLACE OF DEATH:

(a) County Merced

(b) City or town Lindley Twp.
(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 all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Merced ⁶⁵

(c) City or town Rural Lindley
(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 _____

3. (a) PRINT FULL NAME John A. Mock

3. (b) If veteran, name war _____ 3. (c) Social Security No. 1

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced. 9

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive. 3 years 1854

7. Birth date of deceased June 3 1854
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day eleventh
year 1943 hour eleven minute _____ P. M.

21. I hereby certify that I attended the deceased from June 11 1943 to June 11 1943
that I last saw him alive on June 11 1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

89 0 8 hr. _____ min.

Immediate cause of death Coronary thrombosis 2 da.

Due to _____

Due to _____

Other conditions n/a
(Include pregnancy within 3 months of death)

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

10. Usual occupation Farmer

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name John Mock

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

14. Maiden name Dykes

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

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 2

23. Signature Byron J. Artell (M. D. or other) D. O.
Address Bradenton Mo Date signed 6-12-43

16. (a) Informant Jessie Mock

(b) Address Bradenton Mo

17. (a) Burial (b) Date thereof June 12 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director Nail Moss

(b) Address Bradenton Mo

19. (a) 6-14-43 (b) Jessie Mock
(Date received local registrar) (Registrar's signature)

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

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

Paul Moore

Licensed Embalmer No. 2634

P. O. Address Juniper Me

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.

Registration District No. 210 Primary Registration District No. 5769

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

1. PLACE OF DEATH:

(a) County Mercer
 (b) City or town Lindley Twp
(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 John A. Mock
 3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race sw
 6. (a) Single, widowed, married, divorced widower
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 3
(Month) (Day) (Year)

8. AGE: Years 89 Months 0 Days 0
(less than one day) 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) _____ (b) Jessie Alley
(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 _____ day _____
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above
 immediate cause of death Coronary Thrombosis Duration

Due to _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-21990