

FILED DEC 7 1943

State File No. \_\_\_\_\_

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 154

1. PLACE OF DEATH

(a) County Werners

(b) City or town Washburn  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp # 3 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months 20 days  
(Specify whether)

In this community Small  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates

(c) City or town Puckerville  
(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 Carlisle Douglas

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2  
year 1943 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 13  
1943, to Nov 2 1943  
that I last saw him alive on Nov 1 1943  
and that death occurred on the date and hour stated above.

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 June 18 1879  
(Month) (Day) (Year)

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

Hypertensive Cardiovascular  
renal disease

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

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

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

64 4 15 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Farmer - Hospital attended

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_ 9

13. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ 9

15. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Employment application

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof Nov 7-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myers Bros Bates Co

18. (a) Signature of funeral director Frank Lee

(b) Address Appleton City Mo

19. (a) 11-2-43 (b) Harold B. Bewick  
(Date received local registrar) (Registrar's signature)

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 Wm J Cremer (M. D. or other) \_\_\_\_\_  
Address Madras Date signed 11/2/43

1331

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

RECEIVED

District Health Officer No. 71

District File Number 11-43-1293

Date Filed 12-6-43

**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 on the 9th day Nov 1943..... Registered Apprentice No.....  
working under my personal supervision.

Signed Frank Lee.....

Licensed Embalmer No. 1099.....

P. O. Address Appleton City Wis.....

**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.**