

Registration District No. 324

Primary Registration District No. 6092

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Malta Bend, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Grand Pass Turp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 23 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Malta Bend, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

John Wansing

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 Widow  
6. (b) Name of husband or wife yestrude sloppoff 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 20 1867  
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business

12. Name John Wansing  
13. Birthplace Malta Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Cathryn Luckenota  
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anne Baches

(b) Address Malta Bend, Mo.

17. (a) buried (b) Date thereof 3/19/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shackelford Mo.

18. (c) Signature of funeral director J. Leslie Swamy

(b) Address Malta Bend, Mo.

19. (a) 3-18-45 (b) mother  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6, year 1945 hour 5 A.M. minute - M.

21. I hereby certify that I attended the deceased from 3-1, 1945, to 3-16, 1945.  
that I last saw him alive on 3-15, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cardio Vascular Renal Disease Chronic

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy 13/10

Duration \_\_\_\_\_  
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 Geo A. Kellum (M: D. or other) \_\_\_\_\_  
Address Waverly Mo. Date signed 3-17-45

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

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

4/10/45

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 J. Leslie Sussung  
Licensed Embalmer No. 3235

P. O. Address Marshall, 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, fact should be so stated above.