

FILED MAY 8 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 5557

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Pomona, Mo Rural - Sisson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO (Specify whether)
In this community Two Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Joseph Childers

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

4. Sex Male 5. Color or race W 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 Sept 9th, 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Alfred Childers

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

14. Maiden name Katherine Ollewell

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

16. (a) Informant Henry Thompson

(b) Address Mountain View, Mo

17. (a) Burial (b) Date thereof 4/19, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion Cem,

18. (a) Signature of funeral director None

(b) Address _____

19. (a) 4-20-45 (b) Ruth Hunt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18th
year 1945 hour 12 minute 10 pm.

21. I hereby certify that I attended the deceased from Aug 19 44 to April 18 1945
that I last saw him alive on Apr - 18 - 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: General Debility
Due to old age

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?

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

23. Signature C. R. Ferrell (M. D. or other)
Address W. Va. New Mo. Date signed 4-18-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1105

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.