

FILED MAY 9 1945

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

Registration District No. 177

Primary Registration District No. 5639

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Rural - Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5 1/2 mi South East  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 55 years.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Rural - Washington 54  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5 1/2 mi South East 0  
(If rural, give location)  
(e) Citizen of foreign country? No. 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edgar Filler

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

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

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

7. Birth date of deceased Jan 1867  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Farmer

12. Name Solomon Filler

13. Birthplace Louden Co. Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Julia DeVine

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

16. (a) Informant E. P. Smith

(b) Address Adrian Mo.

17. (a) Burial (b) Date thereof April 19 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hebron

18. (c) Signature of funeral director Bliven & Son

(b) Address Adrian Mo.

19. (a) May 1 - 1945 (b) Wm W. Baker  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17  
year 1945 hour 12:50 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from called  
after death to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Died suddenly before  
due medical assistance & drugs  
Died within 5 minutes  
Due to myocardial attack

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None  
Of autopsy no autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_  
23. Signature W. W. Martin (M. D. or other)  
Address Adrian Mo. Date signed 5-26-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

57  
0  
0

RECEIVED

District Health Officer No. 8,

District File Number

Filed

5/8/45

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 Horace Bluniv

Licensed Embalmer No. 2758

P. O. Address Adessa 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.