

No. 8-43
17-39
X37823

Registration District No. 178

Primary Registration District No. 5661

91

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Highland Jump Rural
(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 3 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lewis 56
(c) City or town Highland Jump 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1945 hour 5:30 minute P. M.
21. I hereby certify that I attended the deceased from Nov. 18
1945, 19____, to Nov. 20, 1945
that I last saw him alive on Nov. 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy 200c

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) _____ (Specify type of injury)
23. Signature M. B. Rodson (M. D. or other) DO
Address Canton, Mo. Date signed 11/23/45

3. (a) PRINT FULL NAME WILLIAM ARTHUR Crist

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

4. Sex male 5. Color or race W 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 Nov. 18 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hr. _____ min.

9. Birthplace LEWIS CO, MO. 1
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Oscar Crist 1
13. Birthplace LEWIS County, MO. 1
(City, town, or county) (State or foreign country)
14. Maiden name Marian Brown
15. Birthplace LEWIS County, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Anna K. Ball
(b) Address Ewing, Mo

17. (a) Burial (b) Date thereof Nov-21-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Durham, Mo

18. (a) Signature of funeral director Thomas Ball
(b) Address Ewing, Mo

19. (a) 11-29-45 (b) P.W. Jennings, M.D.
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No: 10

District File Number 1-46-96

Date Filed JAN-23-1946

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 Thomas Buel

Licensed Embalmer No. 1944

P. O. Address Ewing, 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.

Registration District No. 178 Primary Registration District No. (5661)

1. PLACE OF DEATH:

(a) County Lewis

(b) City or town Paris Highland 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 years, months or days)

3. (a) PRINT FULL NAME Wm a. cut

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

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

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

7. Birth date of deceased Nov. 18
(Month) (Day) (Year)

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

9. Birthplace Mo
(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) 11-29-45 (b) P.W. Jennings, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lewis

(c) City or town Highland Twp.
(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 _____ Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

3/10/10

can be used as a