

FILED FEB 5 1946

Registration District No. **254**

Primary Registration District No. **4385**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Koshkonong
(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)
In this community 26 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon **75**
(c) City or town Koshkonong **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) **0**
If yes, name country _____

3. (a) PRINT FULL NAME Charles Wallace Pease

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

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

6. (b) Name of husband or wife Jeanette Talmage 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Nov. 14 1895
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
50	1	17	hr. min.

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

10. Usual occupation Rural Mail Carrier

11. Industry or business _____

12. Name William A. Pease

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

14. Maiden name Jennie Blanchard

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

16. (a) Informant Mrs. Chas. W. Pease

(b) Address Koshkonong, Mo.

17. (c) Burial (b) Date thereof 1-1-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Koshkonong Cem.

18. (a) Signature of funeral director Des Starr

(b) Address Thayer, Mo.

19. (a) 2-2-46 (b) Maryne Therman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31
year 1945 hour 3 minute 10 A. M.

21. I hereby certify that I attended the deceased from July 1945 to Dec 31 1945
that I last saw him alive on Dec 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cornary Heart Disease
Due to Hypertension
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature Des Starr (M. D. or other) MD

Address Thayer, Mo. Date signed 2-46
Cooper

MOTHER FATHER

352

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

RECEIVED

District Health Officer No. 5,

District File Number 246118

Date Filed 2-1-46

FEB 1 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.....

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.

B
5
3880

Registration District No. 254

Primary Registration District No. 4385-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Koshkoning
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Charles W. Pease

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 m

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

7. Birth date of deceased no 14 19
(Month) (Day) (Year)

8. AGE: Years 50 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) 2-2-46 (b) Majorie Thomas
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 _____ Day _____
Year 19 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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

3534