

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall Mo

(c) Name of hospital or institution: Park ave. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 55 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline 97

(c) City or town Marshall 1  
(If outside city or town limits, write "RURAL")

(d) Street No. Park ave. 2  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES WHITNEY

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mch day 20  
year 1946 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from 1946 to 1946 that I last saw him live on Dec 19 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

6. (b) Name of husband or wife Mary G Whitney 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Oct - 19 - 1870  
(Month) (Day) (Year)

Duration \_\_\_\_\_

Due to Cerebral Hemorrhage 14 hrs

Due to Hypertension 7 yrs

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 70 Months 5 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation unemployed

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy 3

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Bud Whitney

13. Birthplace Mo. 1 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Mrs Charles Hinslow (b) Address Marshall mo

17. (a) Burial (b) Date thereof 3-22-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall mo

18. (a) Signature of funeral director Harry Hershberger (b) Address Marshall mo

19. (a) 3/20/46 (b) Mrs T.O. Weather  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

White at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 3/29/46

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

10705

RECEIVED

District Health Officer No. 3,

District File Number \_\_\_\_\_

Date Filed 4-13-46

**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 Harry Hershberger

Licensed Embalmer No. 4357

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.