

1. PLACE OF DEATH:

(a) County COOPER

(b) City or town RODNEVILLE  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
VAN RAVENS WAY 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 WEEKS (Specify whether  
In this community 3 WEEKS years, months or days)

3. (a) PRINT FULL NAME SIAS MONROE MOREHEAD

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife BEITHA MOREHEAD 6. (c) Age of husband or wife if 68 years

7. Birth date of deceased AUG 11 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>8</u>	<u>9</u>	hr. ___ min.

9. Birthplace PETIS Co Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation LABOR

11. Industry or business GENERAL WORK

MOTHER FATHER { 12. Name BARNEY MOREHEAD

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

14. Maiden name HARRIET LUCAS

15. Birthplace Mo 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Edith Byford

(b) Address Marshall Mo

17. (a) BURIAL (b) Date thereof 4. 23. 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salt Pond Mo

18. (a) Signature of funeral director R.C. Carter

(b) Address First St Mo

19. (a) 4-22-46 (b) Clay Moore  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SALINE 97

(c) City or town SWEET SPRINGS 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 11. 2050 EAST ST. 0  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 20<sup>th</sup>  
year 1946 hour 9<sup>45</sup> minute AM

21. I hereby certify that I attended the deceased from March 20 1946 to April 20 1946

that I last saw h. alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage from bladder Duration 1 week

Due to Suprapubic prostatic

Due to Adenoma prostaticae

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

Major findings: Of operations Adenoma prostaticae PHYSICIAN \_\_\_\_\_

Of autopsy None Underline the cause to which death should be charged statistically. 518

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 nd

23. Signature Allen Reavory (M. D. or other) \_\_\_\_\_

Address Brownville Mo Date signed 4.22

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

11572

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 5-8-46

RECEIVED  
MAY 10 1946

RECEIVED  
MAY 10 1946

RECEIVED  
MAY 10 1946

RECEIVED  
MAY 10 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 W. C. Carter

Licensed Embalmer No. 3573

P. O. Address 127 E. 9th St.

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.