

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 910

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Atlanta  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
at home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 4 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis  
(c) City or town Atlanta  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Chlorea Rhoda Partlow

3. (b) If veteran, name war No 3. (c) Social Security No. none

4. Sex Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife High D Partlow 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased Jan 16 1879  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 3 6 hr. min.

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

10. Usual occupation housewife

11. Industry or business at home

12. Name Jessie Parrish

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

14. Maiden name Lydia Darrow

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

16. (a) Informant High Partlow

(b) Address Atlanta Mo

17. (a) Burial (b) Date thereof 4/24/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial Mo

18. (a) Signature of funeral director Jessie L. Shell

(b) Address Atlanta Mo

19. (a) 4-24-46 (b) W. S. Sherman MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22  
year 1946 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from April 22, 1946  
to \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw he/she alive on April 22, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Hypertension

Due to Arteriosclerosis

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 2

23. Signature W. S. Sherman MD (M. D. or other) MD

Address Pacific Date signed April 25, 1946

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

**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..... *Geo. L. Smith*.....

Licensed Embalmer No. *3008*.....

P. O. Address..... *Pacific 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:**