

No. 2
5-43
-17-39
K36671

FILED MAR 21 1947

Registration District No. _____ Primary Registration District No. **5053** Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Barry
 (b) City or town "Rural"
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1 Mi. W. of Viola, Mo. /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community Most of life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry
 (c) City or town "Rural"
(If outside city or town limits, write "RURAL")
 (d) Street No. 1 mi. W. Viola, Mo.
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME THOMAS HENRY WILLYARD

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 Olive McKee 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec. 18, 1899
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Hardin County, Ky. /
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Louis Henry Willyard
 { 13. Birthplace Ky. /
 { 14. Maiden name Mary Holeman (State or foreign country) Ky.
 { 15. Birthplace Ky. /
(City, town, or county) (State or foreign country)

16. (a) Informant Olive Willyard
 (b) Address Viola, Missouri

17. (a) Burial (b) Date thereof 1-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Viola Cem.

18. (a) Signature of funeral director W.C. Koon

(b) Address Cassville, Mo.

19. (a) 8-11-47 (b) Gene Hudson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10th
 year 1947 hour 7:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 1944, to Nov. 1946
 that I last saw him alive on Nov. 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration _____
 Due to High blood pressure also
arteriosclerosis

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? _____

23. While at work _____ (Specify type of place) _____
 (e) Means of injury _____

Signature Glenn J. Salvo M.D. (M. D. or other) _____
 Address Cassville, Mo. Date signed Jan 15

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed.....

J. C. Canada

Licensed Embalmer No. *4190*

P. O. Address..... *Cassville, 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. 12

Primary Registration District No. 5053

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Rural
(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. (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Thomas H. Willyard
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. years
7. Birth date of deceased. See 18 (Month) (Day) (Year)

8. AGE: Years 73 Months Days (If less than one day, hr. min.)

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)
(c) Place: burial or cremation.

18. (a) Signature of funeral director.
(b) Address.

19. (a) 8/11/47 (Date received local registrar) (b) Mrs. Gene Hudson (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.

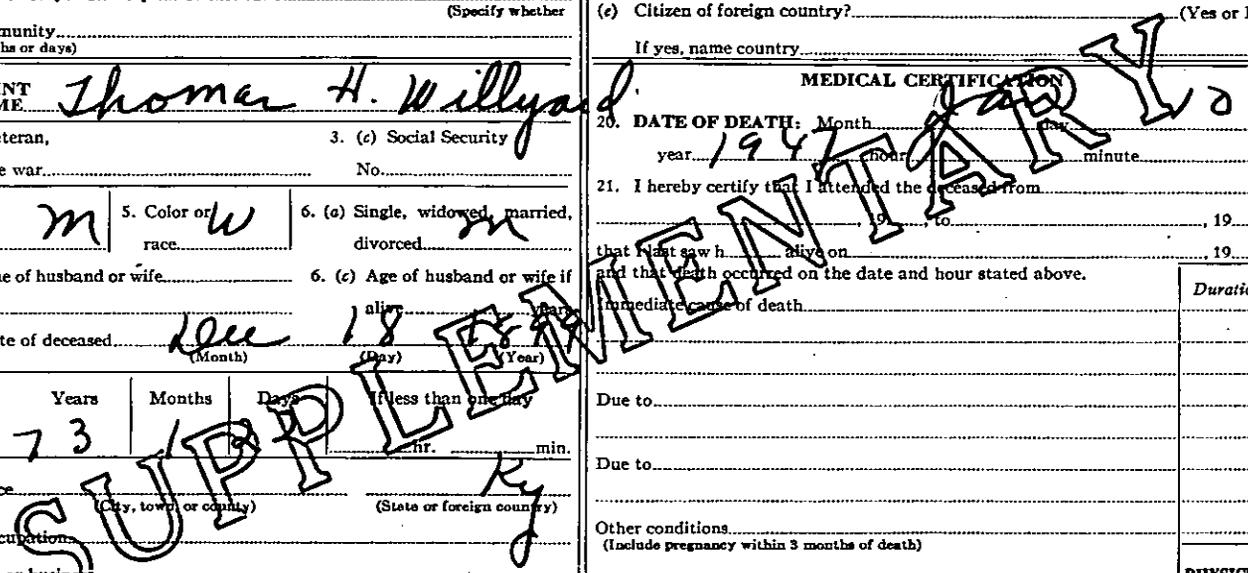
MEDICAL CERTIFICATION
20. DATE OF DEATH: Month year 1947 hour minute M.
21. I hereby certify that I attended the deceased from to , 1947;
that I last saw him alive on , 1947;
and that death occurred on the date and hour stated above.
Immediate cause of death.

Due to.
Due to.
Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations.
Of autopsy.

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) (e) Means of injury
23. Signature. (M. D. or other)
Address. Date signed.



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

SC-7795