

FILED MAR 21, 1947

Registration District No. _____

Primary Registration District No. 3025

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Residence West Plains
(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 No. (Specify whether _____)
In this community 13 years (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME ZONORO SYLVESTER TRANTHAM

3. (b) If veteran, name war _____ 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 Helen Ashworth Trantham
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 4, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 8 22 hr. _____ min.

9. Birthplace Mammoth Spring, Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation Real Estate Dealer

11. Industry or business _____

MOTHER FATHER { 12. Name Z. S. Trantham
13. Birthplace TENN.
(City, town, or county) (State or foreign country)
14. Maiden name Martha Ann Thompson
15. Birthplace TENN.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Helen A. Trantham
(b) Address 422 Grace Ave., West Plains, Mo.
17. (a) Oak Lawn Cem. (b) Date thereof MAR 2, 1947
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation West Plains, Mo.
18. (a) Signature of funeral director Hal Thompson
(b) Address West Plains, Mo.
19. (a) Mar 5 - 1947 (b) Beatrice Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Howell
(c) City or town WEST PLAINS
(If outside city or town limits, write "RURAL")
(d) Street No. 422 Grace Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27,
year 1947 hour 8: minute 15 A. M.

21. I hereby certify that I attended the deceased from 25 Feb, 1947 to 27 Feb, 1947
that I last saw him alive on 25 Feb, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to _____
Due to _____

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

Major findings: Of operations 94B
Of autopsy _____

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 U.D.
23. Signature Beatrice Cook (M. D. or other) U.D.
Address West Plains, Mo Date signed 1 Mar 47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District No. 3474

Date Filed 3-14-47

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

S. L. Duncan

Registered Apprentice No. 390

working under my personal supervision.

Signed Hal Thompson

Licensed Embalmer No. 3408

P. O. Address West Plains,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 141

Primary Registration District No. 5025

1. PLACE OF DEATH:

(a) County Haskell
(b) City or town West Plains
(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 Residence
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Zora S. Jonathan

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 May (Month) 4 (Day) _____ (Year)

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

9. Birthplace _____ (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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town West Plains Mo
(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 July year 1947 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)

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? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____ Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

8848