S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 10 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21344

Registration District No. 157 | Primary Registration District No. 3028 | Registrar's No. 141

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

1. PLACE OF DEATH:

(a) County: Jasper

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

(c) Name of hospital or institution: 705 Fulton St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 66 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jasper 49

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

(d) Street No.: 705 Fulton St. 3
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country: ____

3. (a) PRINT FULL NAME: George Vernon Foland

3. (b) If veteran, name war: ----

3. (c) Social Security No.: ----

4. Sex: male C

5. Color or race: White

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

6. (b) Name of husband or wife: Julia Foland

6. (c) Age of husband or wife if alive: --- years

7. Birth date of deceased: October (Month) 22 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
72	8	6	____ hr. ____ min.

9. Birthplace: Strawtown (City, town, or county) Indiana (State or foreign country) 1

10. Usual occupation: custodian

11. Industry or business: Carthage School System

FATHER
12. Name: William Foland
13. Birthplace: unknwon (City, town, or county) Indiana (State or foreign country) 1

MOTHER
14. Maiden name: Frances Wilkins
15. Birthplace: unknown (City, town, or county) Ohio (State or foreign country) 1

16. (a) Informant: Wilma Salisbury
(b) Address: 705 Fulton, Carthage, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: June (Month) 28 (Day) /47 (Year)
(c) Place: burial or cremation: Park Cemetery

18. (a) Signature of funeral director: Knell Mortuary
(b) Address: Carthage Mo

19. (a) 6-27-47 (Date received local registrar) (b) L. B. Clenton (Registrar's signature) 149

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 year 1947 hour 5 minute 8 M.

21. I hereby certify that I attended the deceased from July 5, 1946, to June 26, 1947; that I last saw him alive on June 25, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis, chronic (myofibrosis)	2 yrs
Due to: Hypertension, chronic	10 yrs
Due to: Nephritis, chronic	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: None	
Of autopsy: None	

PHYSICIAN — Underline the cause of 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? 0
While at work? (Specify type of place) (e) Means of injury

23. Signature: Emery J. McKee (M. D. or other) MD
Address: Carthage Mo Date signed: 6/27/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

47-6-557

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 Frank W. Knell Jr

Licensed Embalmer No. 4440

P. O. Address Carthage

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.