

**FILED** AUG 13 1947

Registration District No. **96**

Primary Registration District No. **472-8-5347**

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

1. PLACE OF DEATH:

(a) County **Dallas**  
(b) City or town **Buffalo** **Rural**  
(c) Name of hospital or institution: **Waller Daniel Home**  
(d) Length of stay: **4 years**  
In this community **4 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dallas**  
(c) City or town **Rural**  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

**Charles Franklin Curtis**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **male**

5. Color or race **wh**

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

6. (b) Name of husband or wife **Hester Ann**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **June 4 1857**

8. AGE: Years **90** Months **1** Days **28** hr. min.

9. Birthplace **Breedree Wisconsin**

10. Usual occupation **farmer**

11. Industry or business **Ret. agric. farmer**

12. Name **Docter Daniel Curtis**

13. Birthplace **New York N. Y.**

14. Maiden name **Mary Ann**

15. Birthplace **Island**

16. (a) Informant **Mrs Waller Daniels**

(b) Address **Buffalo, Mo**

17. (a) **Burial** (b) Date thereof **Aug 3-47**  
(c) Place: burial or cremation **Barnington, Mo**

18. (a) Signature of funeral director **Barnington, Mo**  
(b) Address **Barnington, Mo**

19. (a) **8-10-47** (b) **B. Jones**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **1st** year **1947** hour **10** minute **30 am**

21. I hereby certify that I attended the deceased from **24 July 1947** to **30 July 1947**  
that I last saw him alive on **30 July 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal Bronchial Pneum** Duration **4 days**

Due to **Senile Dementia & arterosclerosis** **7-5 yrs**

Due to **90 yrs old**

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy **107**

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? \_\_\_\_\_  
(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 **O. Griffin** (M. D. or other) **MD**  
Address **Buffalo Mo** Date signed **1 Aug 47**

RECEIVED  
District Health Officer No. 7,  
District File Number 7-47-946  
Date filed 8-12-42

**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. B. Hansen

Licensed Embalmer No. 2488

P. O. Address Camden, N. J.

**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.**