

FILED FEB 11 1948

Registration District No. 282

Primary Registration District No. 4424

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Humansville
(If outside city or town limits, give name of township)
(c) Name of hospital or institution: Paradise Nursing Home
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution 82 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
(c) City or town Osceola
(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 John Whaley

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife June 6. (c) Age of husband or wife if alive 3 years
7. Birth date of deceased June 1865
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 29 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name Unknown 9
13. Birthplace Unknown 9
(City, town or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant County Welfare Office

(b) Address Osceola Missouri

17. (a) Burial (b) Date thereof 2-7-48
(Burial, cremation, or removal) (Month) (Year)

(c) Place: burial or cremation Osceola Cemetery

18. (a) Signature of funeral director F. B. Goodrich

(b) Address Osceola Missouri

19. (a) Feb. 7, 1948 (b) Ralph Garden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4th year 1948 hour 4:00 minute P. M.

21. I hereby certify that I attended the deceased from November 21 1948 to Feb 4th 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 935
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

While at work? (Specify type of place) (c) Means of injury L

23. Signature A. E. Weidner (M. D. or other) DO.
Address Humansville, Mo. Date signed 2-7-48

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

84
0
0

93
2
0
1

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

RECEIVED
District Health Officer No. 7,
District File Number 2-48-52
Date Filed 2-11-48

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 *J. B. Goodrich*
Licensed Embalmer No. *3038*
P. O. Address *Queen Md*

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.