

FILED JUN 30 1948

Registration District No. _____

Primary Registration District No. **5006**

Registrar's No. **213**

1. PLACE OF DEATH:

(a) County **Adair**

(b) City or town **Rural, Greentop**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Greentop #3**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **Greentop #3**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MICHAEL ACTON**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **18**
year **1948** hour _____ minute _____ M.

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 14 1946**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

8. AGE: Years **1** Months **9** Days **5** If less than one day _____ hr. _____ min.

Immediate cause of death **Strangulation from eating peanuts. Child was found in arrival**

Due to _____

Due to _____

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

9. Birthplace **Kirksville, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause of which death should be charged statistically.

11. Industry or business _____

12. Name **Buell Acton**

13. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Charlotte Hays**

15. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

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 **Carl R. Andolf** (M. D. or other) _____
Address **in Adair Co. Mo.** Date signed _____

16. (a) Informant **Buell Acton**
(b) Address **P.O. #3 Greentop, Mo.**

17. (a) **Burial** (b) Date thereof **4-20-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Yarrow Cemetery**

18. (a) Signature of funeral director **Davis Funeral Home**
(b) Address **Kirksville, Mo.**

19. (a) **6-24-48** (b) **W. H. Lambert**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 6-48-1144

Date Filed JUN 29 1948

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, Clarence M. Billo

working under my personal supervision. Registered Apprentice No. _____

Signed

Clarence M. Billo

Licensed Embalmer No. 4375

P. O. Address Kirksville, 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.