

FILED NOV 8 1945

Registration District No. **2222**

Primary Registration District No. **3071**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Slater
(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 _____
In this community 13 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

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

(d) Street No. Emmerson
(If rural, give location)

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

3. (a) PRINT FULL NAME Isaac McBride Plyson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color of hair White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept-10-1857
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1 year 1945 hour 6 minute 15 M.

21. I hereby certify that I attended the deceased from Sept. 19 1945 and that death occurred on the date and hour stated above.

8. AGE: 88 Years 21 Months If less than one day

9. Birthplace Near Sullivan, Saline Co, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Immediate cause of death Senility and Cerebral Hemorrhage.

Due to _____

Due to _____

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

MOTHER FATHER

11. Industry or business _____

12. Name John E Plyson

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

14. Maiden name Elvira Murphy

15. Birthplace Shelburne, Vt.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs C E Tracy

(b) Address Tracy St, Slater

17. (a) burial (b) Date there 10-3-45
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation Denkard near Slater

18. (a) Signature of funeral director Jones & Bager

(b) Address Slater Mo

19. (a) Oct. 5, 1945 (b) ans. Carl C. Metz
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy Jza

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 C. W. Weickard (M. D. or other) _____

Address Slater Mo Date signed 10-2-45

1049

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

RECEIVED

Health Officer No. 8

District File Number

Date Filed 11-5-45

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

Jack Jones

Licensed Embalmer No.

3143

P. O. Address

Slater 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.