

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 15 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

45018
Do not use this space.

1. PLACE OF DEATH

(a) County Cass
(b) Township Grandriver
(c) City 19

Registration District No. 156
Primary Registration District No. 5219

Registered No. _____

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Theodore Wayland Atkinson
801 Cleveland Harrisonville
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ma 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Roseta A.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-1-1869
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 9 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year) 68
11. Total time (years) spent in this occupation 68

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrisonville Missouri

FATHER 13. NAME Allen Atkinson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Lucy Livett
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

17. INFORMANT (ADDRESS) Chas Atkinson Harrisonville

18. BURIAL, CREMATION, OR REMOVAL PLACE Grant Cem DATE Dec 30

19. FUNERAL DIRECTOR (ADDRESS) Atkinson Bros Harrisonville Mo

20. FILED Dec 30 1937 E. M. Guffitt

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 28 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, 9:40 A.M.
The principal cause of death and related causes of importance were as follows:

Tree fell across him - crushing his skull
Died instantly
Date of onset _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? accident Date of injury Dec 28 1937
Where did injury occur? Cass County, Mo
Specify whether injury occurred in industry, in home, or in public place. in woods
Manner of injury. Tree fell across him
Nature of injury. crushed skull

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) E. M. Guffitt M. D.
(Address) Harrisonville Mo

STATEMENT BY LICENSED EMBALMER

I, Hoyd Atkinson, Licensed Embalmer No. 3920

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by, Registered Apprentice No.
working under my personal supervision.

Signed Hoyd Atkinson
Licensed Embalmer No. 3920

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.)