

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.

REC'D APR 23 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

12446

Do not use this space.

1. PLACE OF DEATH

(a) County North Registration District No. 903
 (b) Township Greene Primary Registration District No. 4-545
 (c) City Grant City (d) Street No. _____ St. _____
 (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

Morrison O. Foland 453
 (a) Residence, No. Grant City St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25, 1883
 7. AGE YEARS 54 MONTHS 8 DAYS 0 If LESS than 1 day, _____ hrs. or _____ min.

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. _____
 10. Date deceased last worked at this occupation (month and year) Aug. 1935 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME John Poland
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Amanda Virginia Poland
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT Hugh Poland
 (ADDRESS) Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Oxford DATE March 26, 1938

19. FUNERAL DIRECTOR (NAME) Arch C. Dunfee
 (ADDRESS) Grant City, Mo.

20. FILED 4/8 19 38 Fred Mull
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-24 1938

22. I HEREBY CERTIFY, That I attended deceased from 1-14 1935 to 3-24 1938

I last saw him alive on 3-10 1938. Death is said to have occurred on the date stated above, at 11:00 P.M.

The principal cause of death and related causes of importance were as follows:

Pericarditis of stomach
 Date of onset 1935

Other contributory causes of importance: 4-6

Name of operation _____ Date of _____
 What test confirmed diagnosis? X-Ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____

Where did injury occur? _____
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) S. J. Rasmussen M. D.

(Address) Grant City, Mo.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

12446

Do not use this space.

1. PLACE OF DEATH

(a) County North Registration District No. 903
(b) Township Grant City Primary Registration District No. 45-45 Registered No. _____
(c) City Grant City (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. Morrison & Faland St. □ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 8 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Green, Ind.

13. NAME
John Faland

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Green, Ind.

15. MAIDEN NAME
Emondy V. Verna

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Green, Ind.

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 8-10-19 88 Frank M. M. M. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-24, 1938

22. I HEREBY CERTIFY, That I attended deceased from

to, 19

I last saw h. alive on, 19. Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage 9 Date of onset 1/9/38

Stroke

Other contributory causes of importance 4-6-

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? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) P. J. Ross, M. D.

(Address) Grant City

