

JUL 17 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22936

State File No. _____

Registration District No. 799

Primary Registration District No. 4479

Registrar's No. 31

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 35 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Richard Lane Atterberry

3. (b) If veteran, name war _____ 3. (c) Social Security No. 79-16-9036

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rosa Atterberry 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased November 17 - 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 29 If less than one day hr. _____ min. _____

9. Birthplace Dunning Mo Montgomery
(City, town, or county) (State or foreign country)

10. Usual occupation Car Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Atterberry

13. Birthplace Dunning Mo Montgomery
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Etna Harrison

15. Birthplace Dunning Mo Montgomery
(City, town, or county) (State or foreign country)

16. (a) Informant Rosa Atterberry

(b) Address Slater Mo

17. (a) Burial (b) Date thereof June 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo

18. (a) Signature of funeral director W. J. ...

(b) Address Slater Mo

19. (a) 6-17 (b) W. J. ...
(Date received local registrar) (Registrar's signature)

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. 752 East ...
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 35 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1940 hour 12 minute 30 M.

21. I hereby certify that I attended the deceased from 4-26-40
1940 to 6-16- 1940

that I last saw him alive on 6-16-40 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Paralysis
as result of stroke

Due to Cerebral Hemorrhage 6 wks.

Due to Chronic Cerebral Sclerosis

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following: None

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? None (Specify type of place) (e) Means of injury None

Signature W. J. ... (M. D. or other) MD

Address Slater Mo Date signed 6/17/40

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-13-40

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.