

Missouri STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24842**
Registrar's No. **6369**

Registration District No. **135** Primary Registration District No. **3010**

1. PLACE OF DEATH:

(a) County **Cassell**
(b) City or town **Carrollton**
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **George W. Tatham 350**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **710**

4. Sex **M** 5. Color or race **N** 6. (a) Single, widowed, married, divorced **Married**

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

7. Birth date of deceased **3 8 1888**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	4	—	hr. _____ min. 0

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

10. Usual occupation **Retired Farmer** 1

11. Industry or business _____

12. Name **John Tatham** 5

13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

14. Maiden name **Ann Dickson**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ethel Anderson**

(b) Address **Carrollton, Mo**

17. (a) **Oak Hill Cem** (b) Date thereof **7-10-1940**
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **Wells-Marshall**

(b) Address **Carrollton, Mo**

19. (a) **7-9-40** (b) **W. G. Atwood**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cassell**
(c) City or town **Carrollton**
(If outside city or town limits, write "RURAL")
(d) Street No. **220 South Falgout**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **8**
year **1940** hour **12** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **4-24-39**
19 **7-8-40** to **8-40**, 19 **40**
that I last saw him alive on **7-8**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Insufficiency** ?
Duration _____

Due to _____
Due to _____ **920**

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

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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? _____

130 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. G. Atwood** (M. D. or other) _____
Address **Carrollton, Mo** Date signed **7/9/40**

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

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

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 me

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

Signed R. M. Marshall

Licensed Embalmer No. 7575

P. O. Address Canaan 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, above space should be left blank.