

Registration District No. 243

Primary Registration District No. 5324

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Red Fox (Rural)
(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 1 (Specify whether _____)

In this community 71 yrs years, months or days

3. (a) PRINT FULL NAME Geo W Herd

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Mary Herd 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 18 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months ? Days ? If less than one day _____ hr. _____ min.

9. Birthplace Dallas Texas (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Geo W Herd

13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

14. Maiden name Esther Johns

15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant M. J. Herd

(b) Address Red Fox Mo

17. (a) Mt Olive (b) Date thereof 12-27-19
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive

18. (a) Signature of funeral director L. B. Jones

(b) Address 1315 N. Main St

19. (a) 15-1940 (b) Mrs J N Shewmon
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30

(c) City or town Red Fox (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec - day 25 1
year 1940 hour _____ minute 11 30 P. M.

21. I hereby certify that I attended the deceased from Dec 6
_____, 1940 to Dec 25, 1940
that I last saw him alive on Dec 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio nephritic disease 6 mo
Duration

Due to _____

Due to _____

Other conditions 131a
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

23. Signature C E Feller (M. D. or other) _____

Address Springfield Mo Date signed 12/20/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. T

District File Number 2-41-180

Date Filed 2-4-41

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. 2508

P. O. Address Buffalo, N.Y.

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.