

FILED OCT 6 1941

Registration District No. 181

Primary Registration District No. 5251

Registrar's No. _____

1. PLACE OF DEATH: Ans. 29 Christain Co.
 (a) County Christain
 (b) City or town Country Rural ?
 (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. _____
 In this community All of his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME William M; Teague
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced divorce
 6. (b) Name of husband or wife salla stove 6. (c) Age of husband or wife if alive dead years
 7. Birth date of deceased May 27 1870 (Month) (Day) (Year)

8. AGE: 71 Years UQ UQ Months 3 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name David Teague

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

14. Maiden name Susan Ruby

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

16. (a) Informant Mary Hair

(b) Address Aurora Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Wise Hill Cemetery

18. (a) Signature of funeral director R. E. Thurman

(b) Address Republic Mo.

19. (a) Aug. 31 1941 (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Christain
 (c) City or town Republic Mo Rt 222 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 1941
 year 1941 hour 84 minute 9 M.

21. I hereby certify that I attended the deceased from January 3 1941 to August 29 1941
 that I last saw him alive on August 28 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Prostate Duration 7 to 9 months

Due to _____

Due to _____

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

Major findings: _____ Of operations _____

Of autopsy _____

PHYSICIAN

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? _____

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

23. Signature E. L. Beal M.D. (M.D. or other) _____
 Address Republic Mo Date signed 8/30/41

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

RECEIVED

District Health Officer No. 6;

District File Number 1041-1520

Date Filed OCT 1 1941

S. H. ...

100 ...

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, fact should be so stated above.

11-26-8

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31384

Registration District No. 181

Primary Registration District No. 3251

Registrar's No. _____

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME William M. League

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased May 27, 1870
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days _____ (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov. 10, 1941 (b) Mrs. Louise Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-31334 1941