

Registration District No.

526

Primary Registration District No.

5701

Registrar's No.

1. PLACE OF DEATH:

- (a) County Macon
 (b) City or town Rural Independence
 (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 JOHN FRANKLIN MICHAELS

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

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 20 1941
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 hr. 1 min.

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

10. Usual occupation _____

11. Industry or business Farming

- MOTHER FATHER
 12. Name ELLIS CHARLES MICHAELS
 13. Birthplace BROCK 1 NEBRASKA
 (City, town, or county) (State or foreign country)
 14. Maiden name DOLLY PEARL REICHELT
 15. Birthplace HUMBOLT S. DAKOTA
 (City, town, or county) (State or foreign country)

16. (a) Informant M. O. HARR (Mrs. Pearl Michael)(b) Address ATLANTA MO.17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1941
 (Month) (Day) (Year)(c) Place: burial or cremation Private Home18. (a) Signature of funeral director H. J. Edwards(b) Address Bevier Mo19. (a) (Date received local registrar) (b) 46 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20
 year 1941 hour 8:00A.M. minute _____ M.21. I hereby certify that I attended the deceased from Sept. 20,
1941, to _____, 19____;
 that I last saw him alive on Sept. 20, 1941;
 and that death occurred on the date and hour stated above.Immediate cause of death underdevelopment
of vital organsDue to premature delivery

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 A. L. Warden (M. D. or other) 2
 Address Callao, Mo. Date signed 9/26/41

Duration

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged statistically.

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

176

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 *J. H. Edwards*
Licensed Embalmer No. 1961
P. O. Address Bevier 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31965

Registration District No. 526

Primary Registration District No. 5701

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural Independence
(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 John L. Michaels

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 g

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

7. Birth date of deceased Sept 20 1941
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov 8 1941 (b) Ruth Mcneely
(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 CERTIFICATE FROM

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

21. I hereby certify that I attended the deceased from _____
to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

1941

S-31965