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4-41  
7-39  
X26390

Registration District No. **689**

Primary Registration District No. **3033**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Pike**

(b) City or town **Louisiana Mo.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**421 Douglas St.**  
(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 1** (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pike 082**

(c) City or town **Louisiana**  
(If outside city or town limits, write "RURAL")

(d) Street No. **421 Douglas**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Cecil Mijamin Templeton**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **491-14-1645**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sep** day **19**  
year **1941** hour **12** minute **05 A.M.**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Edith Berry**

6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **Oct 9 - 1880**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sep 9** 19**41** to **Sep 18** 19**41**  
that I last saw him alive on **Sep 18** 19**41**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**

Due to **neplentis**

Due to **hypertension**

8. AGE: Years **60** Months **11** Days **10** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **1318**

Of autopsy \_\_\_\_\_

9. Birthplace **Louisiana Mo n**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Cemetery Sexton**

11. Industry or business \_\_\_\_\_

12. Name **Sam'l W Templeton**

13. Birthplace **Pike Co Mo n**  
(City, town or county) (State or foreign country)

14. Maiden name **Sarah McLean**

15. Birthplace **Isle of Coll Scotland n**  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant **Mo Willie Edmonds (Sister)**

(b) Address **Louisiana Mo**

17. (a) **Burial** (b) Date thereof **9-21-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **River View Louisiana Mo**

18. (a) Signature of funeral director **F. H. Hays**

(b) Address **Louisiana Mo**

19. (a) **9-20-41** (b) **F. H. Hays**  
(Date received local registrar) (Registrar's signature)

23. Signature **Emil Mayer** (Physician)  
Address **Louisiana Mo** Date signed **9/20/41**

(Licensed Embalmer's Statement on Reverse Side)

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

2  
2  
1

RECEIVED

District Health Officer No. 10

District File Number 10-44-1836

Date Filed OCT 13 1941

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.....

.....  
working under my personal supervision.

*George O. Hagner*

Registered Apprentice No. ....

Signed *George O. Hagner*

Licensed Embalmer No. 3773

P. O. Address Louisiana

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.