

Registration District No. **77**

Primary Registration District No. **5960**

Registrar's No. **24**

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Stahl
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)
In this community 40 years

3. (a) PRINT FULL NAME William W. Belay

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

4. Sex male 5. Color or race nr. 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Deanna J. Belay 6. (c) Age of husband or wife 41 years
7. Birth date of deceased June 5 - 1863
(Month) (Day) (Year)

8. AGE: Years 89 Months 4 Days If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name William W. Belay

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Don't know
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant H. E. Olos Stahl Mo.

(b) Address

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

(c) Place: burial or cremation lay, burial

18. (a) Signature of funeral director H. E. Olos Stahl

(b) Address

19. (a) Oct 11 - 1941 (b) Marnie Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam **86**
(c) City or town Stahl **0**
(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 Oct day 4
year 1941 hour 9 minute 45 P.

21. I hereby certify that I attended the deceased from July 1 to July 7, 1941, that I last saw him alive on July 1, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Nephritis
Due to
Due to

Other conditions
(Include pregnancy within 3 months of death) 1318

Major findings: None
Of operations
Of autopsy None

Duration 10 years

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 H. T. Garrison (Name or other)
Address Springer Mo Date signed 10-5-41

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

RECEIVED

District Health Officer No. 1A

District No. *11-41-1981*

Date Filed *6 1981*

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.