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State File No.

Registration District No.

Primary Registration District No. 5131

Registrar's No. 474

1. PLACE OF DEATH: *Butler*

(a) County: *Butler*

(b) City or town: *Butler*

(c) Name of hospital or institution: *R.P.H. Hospital*

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Mo*

(b) County: *Butler*

(c) City or town: *Butler*

(If outside city or town limits, write "RURAL")

(d) Street No.: *R#1* (If rural, give location)

(e) Citizen of foreign country? *P* (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: *Wayne Hosen*

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: *0*

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: _____ (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: *child*

11. Industry or business: _____

MOTHER FATHER

12. Name: *Clayton Hosen*

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

14. Maiden name: *Daley*

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

16. (a) Informant: *Clayton Hosen*

(b) Address: _____

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

(c) Place: burial or cremation: _____

18. (a) Signature of funeral director: *Frank Russell*

(b) Address: _____

19. (a) *12-20-41* (b) *W. H. Hosen*

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *11* day *21*

year *41* hour _____ minute _____ M.

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

that I last saw h_____ alive on _____, 19____;

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

Immediate cause of death: *premature*

Due to: _____

Due to: _____

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

Major findings: *159*

Of operations: _____

Of autopsy: _____

Duration

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: *0*

23. Signature: *J.P. Miller* (M. D. or other)

Address: *Ballou Ark* Date signed: *12-21-41*

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

RECEIVED

District Health Office No. 2,

District File Number 1241-1716

Date Filed: 12-29-41

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.....

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.