

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19282

FILED MAY 25 1943

Registration District No. 381

Primary Registration District No. 6183

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Marion, Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sullivan Co. Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 years
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME FRANCIS R. W. ATWOOD

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, 2 divorced WIDOWED

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

7. Birth date of deceased Sept 21 1872
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name John Atwood

13. Birthplace Indiana 1
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Geo Atwood

(b) Address Pallick

17. (a) Burial (b) Date thereof 4-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marion, Mo

18. (a) Signature of funeral director James R. Green

(b) Address Milan, Mo

19. (a) May 1 1943 (b) Mrs R. D. Green
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Milan Mo
(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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1943 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 1941 to April 22 1943
that I last saw him alive on April 21 and that death occurred on the date and hour stated above.

Immediate cause of death acute endocarditis Duration 2 wks

Due to Chronic endocarditis 3 yrs.

Due to Myocardial atrophy unknown

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 97

23. Signature Geo Simpson (M.D. or other) MD

Address Milan Date signed 7-23-43

RECEIVED

District Health Officer No. 10

District File Number 354843907

Date Filed MAY 21 1947

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

Harold C. Rogers

Licensed Embalmer No. 3792

P. O. Address Melvin Ma

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, above space should be left blank.