

FILED JUL 12 1943

Registration District No. 1

Primary Registration District No. 4012

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Rock Port Mo.
(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 _____ (Specify whether)
In this community Entire Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison 3
(c) City or town Rock Port Mo.
(If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ann Nylie Cheesman

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Charles L Cheesman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 25 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 2 9 hr. _____ min.

9. Birthplace Rock Port Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business House Wife

12. Name William Bowler Guthrie

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

14. Maiden name Elizabeth Ann Dargatz

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

16. (a) Informant W. M. Cheesman

(b) Address Watson Mo.

17. (a) Burial (b) Date thereof 5 7 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gravelly

18. (a) Signature of funeral director B. Bertran

(b) Address Rock Port Mo.

19. (a) May 8 1943 (b) Mc Herbert Taurand
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th
year 1943 hour 2 PM minute 30 M.

21. I hereby certify that I attended the deceased from May 4th 1943
2 PM to May 4th 1943
that I last saw her alive on May 4th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 8201

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? _____

23. Signature Chas. J. Settle M.D. (Specify type of physician) (M. D. or other)
Address Rock Port Mo. Date signed 5-4-43

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

MOTHER—FATHER

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 By Me

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

J. B. Bertram

Licensed Embalmer No. 4024

P. O. Address Rock Port 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.