

FILED DEC 13 1943

Registration District No. **190** Primary Registration District No. **5703** Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **Irvington**  
 (b) City or town **Chula, Rural Medicine City**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution:  
 In this community **73 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Irvington**  
 (c) City or town **Chula Rural**  
 (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 **0**

3. (a) PRINT FULL NAME **ISAIAH W. TRANSUE**  
 (b) If veteran, name war (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **1**  
 year **1943** hour **4** minute **25** M.

4. Sex **m.** 5. Color or Race **w.** 6. (a) Single, widowed, married, divorced **married**  
 6. (b) Name of husband or wife **Lemuel Transue** 6. (c) Age of husband or wife if alive **69** years  
 7. Birth date of deceased **Mar. 16 1865**  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1934** to **Nov 1**, 19**43**  
 that I last saw him alive on **Nov 1**, 19**43**  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death **Paralysis Agitans** **10 yrs** Duration

8. AGE: Years **77** Months **11** Days **15** If less than one day **hr. min.**

Due to **Paralysis Agitans**  
 Due to  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations **JTC**  
 Of autopsy

9. Birthplace **Exp. Pa. 1**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business **Farming**  
 12. Name **William Transue**  
 13. Birthplace **Exp. Pa. 1**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Victoria Smith**  
 15. Birthplace **Exp. Pa. 1**  
 (City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant **C. J. Transue**  
 (b) Address **Chula Mo.**  
 17. (a) **Rural** (Burial, cremation, or removal) (b) Date thereof **11-3-1943**  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation **Plains, Mo.**  
 18. (a) Signature of funeral director **E. P. Robinson**  
 (b) Address **Farld, Mo.**  
 19. (a) **Nov 2 1943** (Date received local registrar) (b) **Ruth J. Norman** (Registrar's signature)

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 **W. H. McQuinn** (M. D. or D. O.)  
 Address **Chula Mo.** Date signed **Nov 2 1943**

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

MOTHER FATHER

1006

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.....

*James M. Robertson*....., Registered Apprentice No. *253-*  
working under my personal supervision.

Signed *E. J. Robertson*.....

Licensed Embalmer No. *2465*.....

P. O. Address *Farede, 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.