Form No. 2
1-4-41
5-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18435

FILED JUN 7 1944

Registration District No. 1 [illegible]

Primary Registration District No. 3034

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Higginsville, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
414 Fair Ground Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

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

(d) Street No. 414 Fair Ground Avenue
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Edward Wasson Atchley

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife ____

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

7. Birth date of deceased July (Month) 21 (Day) 1851 (Year)

8. AGE: Years 92 | Months 9 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Meigs County (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation Earlier life farming

11. Industry or business later years musician

FATHER
12. Name Thomas Vernon Atchley
13. Birthplace Meigs County (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Elizabeth Ann Wasson
15. Birthplace Meigs County (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant James A. Atchley James A. Atchley
(b) Address Higginsville Mo.

17. (a) Higginsville (Burial, cremation, or removal) (b) Date thereof 5-18-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Alfred Hafer & Sons
(b) Address Higginsville, Mo.

19. (a) 5-17-1944 (Date received local registrar) (b) Dr. W. B. Bracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1944 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from May 6, 1944 to May 15, 1944 that I last saw him alive on May 15, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cortico Calcinosis	Many Years
Due to:	
Due to:	
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or Coroner)
Address Higginsville, Mo. Date signed 5/19/1944

11/89 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-6-

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. Forrest G Hogan

Licensed Embalmer No. 4358

P. O. Address. Higginsville. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.