

FILED MAY 24 1944

Registration District No. 5708

Primary Registration District No. 5708

Registrar's No. 60

1. PLACE OF DEATH:

(a) County MCDona'd
 (b) City or town Rural Erie TWP.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Anderson MO. R.F.D. # 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 40 Yrs. (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT
FULL NAMEWAYNE WAKEFIELD3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex Male 5. Color or
race White 6. (a) Single, widowed, married,
Divorced Single6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased April 2, 1965
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
79 0 29 hr. min.9. Birthplace _____ Michigan
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Farming12. Name Unknown13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)16. (a) Informant Erick Barclay(b) Address Goodman MO.17. (a) Removal (b) Date thereof 5-2-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
St. Johns Mich.

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Chas. Williams(b) Address Goodman MO.19. (a) 5/6/44 (b) Mrs. C. W. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County MCDona'd
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. Anderson MO R.F.D. # 3
 (If rural, give location)
 (e) Citizen of foreign country? N-NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st,
year 1944 hour 7 minute 10.4 M.21. I hereby certify that I attended the deceased from
Feb 12 1944 to Apr 30 1944that I last saw him alive on Apr 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to myocardial failureDue to cardiac enlargementDue to pneumonia ✓Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____Of autopsy ADDITIONAL
SUPPLEMENTARY
INFORMATION22. If death was due to natural cause 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 223. Signature C. D. James (M.D. or other) D.O.Address Goodman MO Date signed 5/1/44

RECEIVED

District Health Officer No. 6;

District File Number 544-601

Date Filed MAY 17 1944

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.

Registration District No. 193

Primary Registration District No. 0709

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Bevier
(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 _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Wayne Wakefield
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased April 2 (Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days _____ (Unless less than one day) min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mich.

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death myocardial failure

Due to cardiac enlargement

Due to following lobar pneumonia

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of operations _____ Of autopsy _____

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 E. D. James (M. D. or other) _____

Address Goodman, Mo. Date signed _____

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

SUPPLEMENTARY INFORMATION REQUESTED

MOTHER FATHER

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

18576

18576