

FILED JUN 12 1944

Primary Registration District No.

45044 5735

Registrar's No.

1. PLACE OF DEATH:

(a) County Macomb
(b) City or town Atlanta - Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Jackson Run
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Archie Carroll Atterbury

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 (Day) (Year)

7. Birth date of deceased: July (Month) 18 (Day) 1881 (Year)

8. AGE: Years 62 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Atlanta (City, town, or county) MO (State or foreign country)

10. Usual occupation Salesman

11. Industry or business _____

12. Name B. C. Atterbury

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

14. Maiden name Ana Lane Davis

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

16. (a) Informant Corine Harrison

(b) Address Atlanta

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-44 (Month) (Day) (Year)

(c) Place: burial or cremation 1st Tabern

18. (a) Signature of funeral director Blackburn

(b) Address Atlanta

19. (a) May 9 (Date received local registrar) (b) Mrs. G. L. Campbell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Macomb
(c) City or town Atlanta (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes) No
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1944 hour 12:05 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 27 1944 to April 27 1944; that I last saw him alive on didn't and that death occurred on the date and hour stated above.

Immediate cause of death Coronary heart disease Duration _____

Due to unknown

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94a

Major findings: 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) (c) Means of injury Car

23. Signature Dr. Corine Harrison (Physician's signature) (Date signed 4/3/44)

Address Atlanta, MO

JUN 12 1944

RECEIVED

District Health Officer No. 10

District File Number 6-44-115

Date Filed JUN 9 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.