

FILED AUG 19 1944

Registration District No.

Primary Registration District No. 5-637

Registrar's No.

36

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

4000

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Rural
(c) Name of hospital or institution: County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 2 years, months or days)

3. (a) PRINT FULL NAME JOHN-DE MASTERS

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

4. Sex male 5. Color or race whit 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased 3-18-1880
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation unknown

11. Industry or business unknown

12. Name unknown 9

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

14. Maiden name unknown 9

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

16. (a) Informant County Home Records
(b) Address Wellington Mo

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

(c) Place: burial or cremation County Home

18. (a) Signature of funeral director W. R. Breen
(b) Address Wellington Mo
19. (a) Aug. 4-1944 (b) Mrs. W. F. Baker
(Dated local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette
(c) City or town Rural 54
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1944 hour 11 minute A M.

21. I hereby certify that I attended the deceased from July
1944 to July 8, 1944
that I last saw him alive on July 1, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis -
Chronic - arthritis -
Duration many years
many years

Due to _____
Due to _____

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

Major findings: 9M
Of operations _____
Of autopsy _____

Duration
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. R. Breen (M. D. or other MD)
Address Higginsville Mo Date signed 7-8-1944

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 8-8-44

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 *M. P. Owen*
Licensed Embalmer No. *H 305*
P. O. Address *Wilmington, N.C.*

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, above space should be left blank.