

FILED SEP 9 1944

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 42

1. PLACE OF DEATH

(a) County Lafayette
(b) City or town Livingston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 12th Mann
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 yrs - years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Livingston
(If outside city or town limits, write "RURAL") 51
(d) Street No. 12th Mann
(If rural, give location) 5
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH ANTON

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

4. Sex ma 5. Color or race w 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rose Thomas 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased Jan 10 1885
(Month) (Day) (Year)

8. AGE: Years 59 Months 4 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Shoe repair

11. Industry or business _____

MOTHER FATHER

12. Name Not known
13. Birthplace " " " " (City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace " " " " (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Anton

(b) Address Livingston

17. (a) Burial (b) Date thereof 6-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Livingston

18. (a) Signature of funeral director F. F. Schupel

(b) Address Livingston

19. (a) Sept-1-44 (b) Mrs. Fred Schwab
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1944 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1/14/44 19____ to 6/5/44 19____

that I last saw him alive on 6/5/44 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular degeneration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 46

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) (e) Means of injury _____

23. Signature Dr. P. H. ... (M. D. or other) _____

Address Livingston Mo. Date signed 8/15/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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RECEIVED
District Health Officer No. 8,

DEC 30 1957

Date filed 9-8-47

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 Garrett F. Jumper

Licensed Embalmer No. 3275

P. O. Address Livingston, 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.