

FILED SEP 21 1944

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 897

1. PLACE OF DEATH:

(a) County: Buchanan
(b) City or town: Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sisters Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 yrs (Specify whether years, months or days)
In this community: 5 yrs

3. (a) PRINT FULL NAME: PALEN W. PLANTS

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: 1

6. (b) Name of husband or wife: None 6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Jan 29 1874
(Month) (Day) (Year)

8. AGE: Years: 70 Months: 6 Days: 22 If less than one day: hr. min.

9. Birthplace: Ind. 1
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Farmer

12. Name: unknown

13. Birthplace: Ind. 1
(City, town, or county) (State or foreign country)

14. Maiden name: unknown

15. Birthplace: Ind. 1
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs J.W. Plants

(b) Address: Mapsville Mo

17. (a) Removed (b) Date thereof: 8-21-44
(Burial, cremation, or removal) (Month), (Day), (Year)

(c) Place: burial or cremation: mapsville Mo

18. (a) Signature of funeral director: John O. Brown

(b) Address: Mapsville Mo

19. (a) 8/21/44 (b) Delen J. Fuchs
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: De Kalb
(c) City or town: Mapsville Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 4 mile S.E.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 31
year: 1944 hour: 8 minute: 55 A.M.

21. I hereby certify that I attended the deceased from: Aug 16 1944 to: Aug 21 1944
that I last saw him/her alive on: Aug 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal obstruction due adhesions terminal ileum
Due to: ileum

Due to: Pulmonary embolus
Other conditions: Pulmonary embolus
(Include pregnancy within 3 months of death)

Major findings: Obstruction of terminal ileum due to adhesions
Of operation: Pulmonary embolus
Of autopsy: Pulmonary embolus

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: J.P. Sever M.D. or other:
Address: Mapsville Mo Date signed: 8-21-44

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

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.....

John B. Brame

Licensed Embalmer No. 3933

P. O. Address Wayville

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.