No. 2
8-43
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 9 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37891

Registration District No. 141 — Primary Registration District No. 30 2 J — Registrar's No. 98

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

6-1-1

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Hours
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas 107
(c) City or town Hartshorn, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Leonard E Atchison

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 23rd 1943
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
1			hr. min.

9. Birthplace St Louis Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Edgar Atchison

13. Birthplace Eminence, Mo 0
(City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Mary Stewart

15. Birthplace Eminence, Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Edgar Atchison

(b) Address Hartshorn, Mo

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

(c) Place: burial or cremation Round Springs Mo

18. (a) Signature of funeral director

(b) Address Mountain View, Mo

19. (a) 11-8-44 (b)
(Date received by registrar) (Registrar's signature)

1125

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4th 4th
year 1944 hour 4 minute p. M.

21. I hereby certify that I attended the deceased from 11/4, 1944, to 11/4, 1944; that I last saw h. alive on 11/4 1944 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Kerosene Poisoning — 3 hrs

Due to Respiratory Failure

Due to

Other conditions (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations

Of autopsy

PHYSICIAN

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) X

(b) Date of occurrence X

(c) Where did injury occur? X
(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? X (e) Means of injury

23. Signature Maurice Thompson (M. D. or other) M D

Address West Plains mo Date signed 11/8/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 244605
Date Filed 12-8-44

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, ~~of his~~ ....., Registered Apprentice No. .....,
working under my personal supervision.

Not Embalmed

Signed John F. Dineen

Licensed Embalmer No. 2516

P. O. Address Mountain Grove 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.

S. No. 2B
M—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 141 Primary Registration District No. 3022 Registrar's No. 98

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

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Leonard E. Atchison
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 S

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

7. Birth date of deceased Dec 23 (Month) (Day) (Year)

8. AGE: Years 1 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 23
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 3 hrs
Due to
Due to Respiratory Paralysis
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

SUPPLEMENTARY

1943

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

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) accident
(b) Date of occurrence Nov 4 1944
(c) Where did injury occur? Home (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 Maurice Thompson (M. D. or other) M.D.
Address Date signed 12/6/44

37891