

FILED DEC 11 1944

Registration District No. 243

Primary Registration District No. 4363

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Fairview ~~Franklin~~
(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 1
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73
(c) City or town Fairview 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21
year 1944 hour 12:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 5, 1944, to Sept - 21, 1944
that I last saw him alive on Sept - 10, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Duration

Due to _____

Due to _____

Other conditions 930
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 0

23. Signature O. S. McCall (M. D. or other) _____

Address Wheaton Mo. Date signed 10-24-44

3. (a) PRINT FULL NAME Charles M. Paden

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

4. Sex male 0 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

7. Birth date of deceased March 13 1958
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Paden

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

14. Maiden name unknown

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

16. (a) Informant Elmo Paden

(b) Address Newtonia, Mo.

17. (a) Burial (b) Date thereof Sept 24, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Culver Funeral Home

(b) Address Cassville, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED DEC 7 1944
District Health Officer No.
District File Number 1144-242
Date Filed DEC 7 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 *Margaret Culver*
Licensed Embalmer No. *7389*
P. O. Address *Cassville*

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.

Registration District No. 243

Primary Registration District No. 4363

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Jarvis
(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 _____)

In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Charles M. Paden

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 w

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

7. Birth date of deceased mar 13 1913
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-11 1944 (b) Alpha L. Hale, Jr.
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 12 Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____

that I last saw him/her alive on _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

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) _____

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

38428