

S. No. 2
FORM-5-43
Rev. 5-17-39
X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 8 1944

38532

State File No. _____

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 379

1. PLACE OF DEATH:

(a) County PETTIS

(b) City or town SEDALIA
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1318 So. PARK
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County PETTIS

(c) City or town SEDALIA
(If outside city or town limits, write "RURAL")

(d) Street No. 1318 So. PARK
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN WM. MAY

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 W.D.

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

7. Birth date of deceased FEB 17 1868
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1944 hour 4 minute P M.

21. I hereby certify that I attended the deceased from Nov 23
1944 to Nov 29 1944

that I last saw him alive on Nov 29 1944
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>9</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage Duration 6 days

Due to senility and hypertension

Due to _____

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

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

10. Usual occupation RETIRED

11. Industry or business sewer man

12. Name W^m C. MAY

13. Birthplace _____ (State or foreign country)

14. Maiden name LUCINDA

15. Birthplace _____ (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant MYRTLE M. CAMP

(b) Address KAN. CITY, MO. 7014 WALROND

17. (a) BURIAL (b) Date thereof 12-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CROWN HILL

18. (a) Signature of funeral director Geo. Willard

(b) Address SEDALIA, MO

19. (a) 12/1/44 (b) Mrs Anna Berger
(Date received local registrar) (Registrar's signature)

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. J. Bishop (M. D. or other) _____
Address Sedalia Mo Date signed 2-1-44

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

664

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-7-44

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.....

Licensed Embalmer No. 3868

P. O. Address Seaside

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.