

Registration District No. 225 Primary Registration District No. 4480

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Greentop
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Van Oadol Clinic 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One day (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Roy Milligan Ewing

3. (b) If veteran, name war. 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Vivian McPike Ewing 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Sept 11 1884 (Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 16 If less than one day hr. min.

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

10. Usual occupation Furniture Business

11. Industry or business

12. Name William Ewing

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

14. Maiden name Margaret Caywood

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

16. (a) Informant Mrs. Vivian Ewing

(b) Address Tulsa, Okla

17. (a) Removal (b) Date thereof 11/27/44 (Month) (Day) (Year)

(c) Place: burial or cremation Tulsa, Okla.

18. (a) Signature of funeral director. Beverly Kirksville, Mo.

(b) Address Nov 27 '44

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Tulsa 777
(c) City or town Tulsa 24 (If outside city or town limits, write "RURAL")
(d) Street No. 1035 S. Chymne (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27 year 1944 hour 3:40 minute A: M.

21. I hereby certify that I attended the deceased from 11-26 1944 to Time of death; that I last saw him alive on or 3:40 A.M., 1944 and that death occurred on the date and hour stated above.

Immediate cause of death. Cause of death: Colon. Duration 1 yr.

Due to. Other conditions: none H62 (Include pregnancy within 3 months of death)

Major findings: Of operations: None Of autopsy: None

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?

23. Signature: A. W. Oadof (M. D. or other) While at work? (Specify type of place) (e) Means of injury Date signed 11-27-44

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

800

JUN 22 1945

RECEIVED
District Health Officer No. 10
District File Number 12-44-1139
Date Filed DEC 5 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 Dee Riley

Licensed Embalmer No. 4181

P. O. Address Kearneyville 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.