

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3766

State File No.

Registrar's No. 5

FILED JAN 25 1945

Registration District No. 376

Primary Registration District No. 6165

1. PLACE OF DEATH:

(a) County Stone
(b) City or town rural - Hurley Twp
(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 35 yrs.
(Specify whether years, months or days)
In this community 35 yrs.

3. (a) PRINT FULL NAME George Robert Ailshie

3. (b) If veteran, non 3. (c) Social Security name war. No. 554-22-8326

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elsie Ailshie 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Oct. 18, 1908
(Month) (Day) (Year)

8. AGE: Years 35 Months 4 Days 27 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

MOTHER FATHER
12. Name John Ailshie
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Lydia White
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Elsie Ailshie
(b) Address R#1 Marionville, Mo.

17. (a) burial (b) Date thereof 3-16, 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wrights cemetery

18. (a) Signature of funeral director T.W. Maples
(b) Address Clever, Mo.

19. (a) 3-17-44 (b) Gary manlove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone
rural
(c) City or town Marionville R#1
(If outside city or town limits, write "RURAL")
(d) Street No. Marionville R#1
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 16
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct 13 to Mar 16, 1944
that I last saw him alive on Mar 16, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary tuberculosis
Sec. Roeyne

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

378

8th

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 A.P. C... M.D. (M. D. or other)
Address C... Mo Date signed 5-17-44

RECEIVED
District Health Officer No. 6,
District File Number 145-112
Date Filed JAN 22 1945

JUN 02 1945

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 _____

J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, 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, above space should be left blank.