S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1945

Registration District No. 47

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3008

State File No. 5711

Registrar's No. 18

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1016 Bluff St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 6 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Callaway
(c) City or town Fulton 14
(If outside city or town limits, write "RURAL")
(d) Street No. 1016 Bluff 1
(If rural, give location)
(e) Citizen of foreign country? No 2 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM BRUCE MEADOR

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 widower

6. (b) Name of husband or wife Katie Lee Meador

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

7. Birth date of deceased Sep (Month) 16 (Day) 1859 (Year)

8. AGE: Years 85 Months 3 Days 28 If less than one day ____ hr. ____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business ____

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

MOTHER
14. Maiden name DK Burnett
15. Birthplace DK (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Kathrine McClanahan
(b) Address 1016 Bluff

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (Month) (Day) (Year)
(c) Place: burial or cremation Unity Baptist Cemetery

18. (a) Signature of funeral director ____
(b) Address Wallace Funeral Home

19. (a) 1-16-1945 (Date received local registrar) (b) Josie Morsuck Hoff (Registrar's signature)

1147

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 14 year 1945 hour 10 minute 15P M.

21. I hereby certify that I attended the deceased from At intervals 1941 to 1-14 1945 that I last saw him alive on Jan 9 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Inanition due to Paralysis of throat

Due to Increasing Paralysis following Apoplexy several years ago.

Due to ____

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

Major findings:
Of operations ____
Of autopsy ____

Duration

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature W. O. Payne (M. D. or other)
Address R#6 Fulton Mo Date signed 1-16-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 3-7-45

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 Dennis A. Browning

Licensed Embalmer No. 2784

P. O. Address Fulton 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.