

S. No. 2
M-8-43
v. 5-17-39
X37823

5885

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 12 1945

Registration District No. 73

Primary Registration District No. 5291

Registrar's No. 20

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

1. PLACE OF DEATH:

(a) County Charlton

(b) City or town Charlton

(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 60 years (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Clay

(b) City or town Charlton
(If outside city or town limits, write "RURAL")

(c) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME EPHRAIM ALONZO SQUIRES

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rose Squires

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Oct 13 - 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Madison Co. Easton Ill
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Martin Squires

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

14. Maiden name Sarah Elizabeth Goble

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

16. (a) Informant Rose Squires

(b) Address Charlton Mo.

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof Feb. 16 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Funing Liberty Mo

18. (a) Signature of funeral director Chas. W. Baker

(b) Address Liberty Mo

19. (a) Feb. 17-45 (b) Helen Bailey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14 year 1945 hour 3 minute 05 A.M.

21. I hereby certify that I attended the deceased from April 1940 to Feb. 14 1945
that I last saw him alive on Feb 13 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral occlusion

Due to Arterio sclerosis

Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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 Glenn W. Sanderson (M. D.)
Address Liberty Mo Date signed 2/17/45

Duration 5 yr

Indefinite

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

Health Officer No. 8,

number

3-10-45

APR 2 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

Edgar Arch

Licensed Embalmer No.

3301

P. O. Address

Liberty - 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.