

FILED MAY 14 1945

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 43

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

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: A. S. O. hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs (Specify whether
Life (Specify whether

In this community Life
years, months or days)

3. (a) PRINT FULL NAME Raymond Lee Tjaden

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 Single

6. (b) Name of husband or wife --

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

7. Birth date of deceased March 24 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 4 hr. 20 min.

9. Birthplace Kirkville, Adair Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

MOTHER FATHER } 12. Name Albert Tjaden

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

14. Maiden name Margaret A. Sharpe

15. Birthplace Lewis Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Hunter

(b) Address Lewistown, Missouri

17. (a) Burial (b) Date thereof Mch. 25, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elm Grove Cemty. LaBelle, Mo.

18. (a) Signature of funeral director Norman W. Cochrane
(b) Address Paris, Mo.

19. (a) 4-5-45 (b) D. W. J. Wagner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. A. S. O. hospital
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24th
year 1945 hour 10:00 minute a M.

21. I hereby certify that I attended the deceased from March 24 1945 to March 24 1945
that I last saw him alive on March 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Cranial Hemorrhage Duration
from injury during
delivery from forceps on the
after turning head

Due to Prenatal Hydrocephalus

Other conditions: a slight constriction of
(Include pregnancy within 3 months of death) the a.p. diameter
of the mother's pelvis.

Major findings:
Of operations _____

Of autopsy 820

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 _____

17. (a) Burial (b) Date thereof Mch. 25, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elm Grove Cemty. LaBelle, Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Norman W. Cochrane
(b) Address Paris, Mo.

19. (a) 4-5-45 (b) D. W. J. Wagner
(Date received local registrar) (Registrar's signature)

23. Signature R. B. Bachman (M. D. or other) 200
Address Kirkville, Mo Date signed 3/24/45

RECEIVED

District Health Officer No. 10

District File Number 5-45-830

Date Filed MAY 10 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 *Norman D. Codee*

Licensed Embalmer No. 3721

P. O. Address *Lasalle 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.