

FILED MAY 23 1945

Registration District No.

Primary Registration District No. 4154

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Greenfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Milligan Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29
(c) City or town Greenfield 1
(If outside city or town limits, write "RURAL") 0
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME S.M. Quick

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife Amanda 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Mar 4 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 28 If less than one day hr. min.

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

10. Usual occupation County clerk

11. Industry or business Co. of mayor

12. Name James Thomas Quick

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

14. Maiden name Leticia Martin

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

16. (a) Informant Son Aaron Quick

(b) Address Kansas City

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

(c) Place: burial or cremation Off. Cemetery

18. (a) Signature of funeral director A. L. Samuel

(b) Address Lockwood Mo

19. (a) Mar 23 1945 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21-1945
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from 3-16-1945 to 3-16-1945
that I last saw him alive on 3-16-1945
and that death occurred on the date and hour stated above
Immediate cause of death Arterio Sclerosis Duration

Due to.....

Due to.....

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

Major findings:.....
Of operations.....
Of autopsy.....

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?

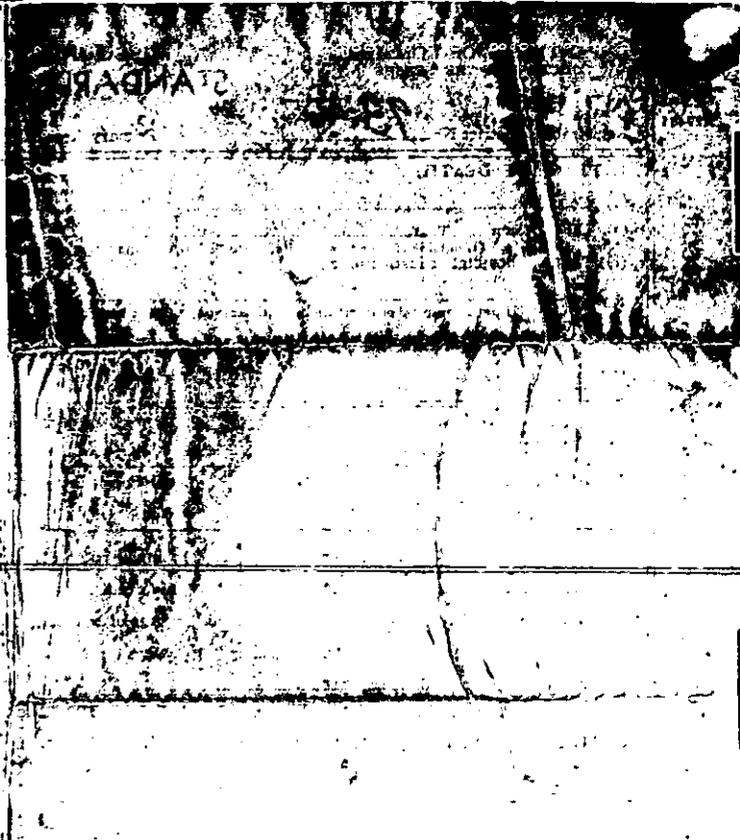
While at work..... (Specify type of place)
(c) Means of injury.....

23. Signature J. D. Combs (M. D. or other)
Address Lockwood Mo Date signed 3-23-45

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

MOTHER FATHER

RECEIVED
District Health Officer No. 61
District File Number 445-468
Date Filed APR 20 1950



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 R. L. Yarnschild

Licensed Embalmer No. 3134

P. O. Address Lockwood 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.

Registration District No. 93 Primary Registration District No. 4154

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Greenfield
(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 _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME S. M. Quick
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Name of husband or wife Armanda 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased ma (Month) 8 (Day) 1930 (Year)

8. AGE: Years 75 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

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

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month mar day 1
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

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 _____ (M. D. or other)
Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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