

FILED JUL 13 1945

Registration District No. 133

Primary Registration District No. 5490

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Harrison  
(b) City or town White Oak Township Rural  
(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 6 months (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison  
(c) City or town New Hampton Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. One & three fourth mile NE of New Hampton  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27  
year 1945 hour 12 minute 30 P.M.  
21. I hereby certify that I attended the deceased from June 27, 1945 to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on June 27, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis  
Duration \_\_\_\_\_

Due to Acute indigestion  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy ASB  
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 P. L. Green (M. D. or other) 200  
Address New Hampton Mo Date signed 6/27/45

3. (a) PRINT FULL NAME Jacob William Everley  
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 2  
6. (b) Name of husband or wife Margret Everly Dierand 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 18 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Joseph Everley  
13. Birthplace Maryland (City, town, or county) (State or foreign country)  
14. Maiden name Susan Hedington  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Jess Everley  
(b) Address Albany Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Foster Cemetery

18. (a) Signature of funeral director W. S. Noble

(b) Address New Hampton Mo

19. (a) June 30-45 (Date received local registrar) (b) Zola Burrows (Registrar's signature)

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

X37823

**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 me  
....., Registered Apprentice No.....  
working under my personal supervision.

**RECEIVED**  
District Health Officer No. 11,  
District File Number.....  
Date Filed.....

Signed W. J. Noble  
Licensed Embalmer No. 2908  
P. O. Address New Hampton 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.**