

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JUL 12 1945

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

20407
Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 136
 (b) Township Hamilton Primary Registration District No. 6498
 or Rural (c) City 1 (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME RUTH DeMAE Sheets

(a) Residence, No. Wascapville, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Harry Sheets
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 1 1920
 7. AGE YEARS 25 MONTHS 0 DAYS 14 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. own home
 10. Date deceased last worked at this occupation (month and year) 6/15/45 11. Total time (years) spent in this occupation 5 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrison County Mo.

FATHER 13. NAME Bert Slaughter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Decatur County La

MOTHER 15. MAIDEN NAME Ruby Sheets

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrison County Mo

17. INFORMANT (ADDRESS) R. D. Sheets, Eagleville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Andover, Mo. DATE 6/18 1945

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm A Marsh, Landon, La

20. FILED 6-21 1945 Chas Adair Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 15 1945

22. I HEREBY CERTIFY, That I attended deceased from June 15 1945 to _____, 19__.

I last saw him _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at 8:00 P.M.

The principal cause of death and related causes of importance were as follows:

Accidental Death
Due to LIGHTNING.

Other contributory causes of importance: None, 1945

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide Accident Date of injury 6-15 1945

Where did injury occur? Rural - Eagleville - Mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. FARM.

Manner of injury Struck By LIGHTNING

Nature of injury Cutaneous Arborescent Current Mark

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify (Signed) Wm McCarter, Jr. (Address) Eagleville - Mo

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.....
myself....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Wm A Marsh*.....

Licensed Embalmer No. *4400*.....

P. O. Address *Lanoni, Ia*.....

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, above space should be left blank.