

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25343**

FILED AUG 9 1945

Registration District No. **377**

Primary Registration District No. **6287**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Wright**
(b) City or town **Mansfield, Rural Pleasant Valley**
(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 **12 years** (Specify whether years, months or days)

In this community

3. (a) PRINT FULL NAME **John Huston Atkinson**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **702-03-5099**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Fannie M. Atkinson** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **May 4, 1880** (Month) (Day) (Year)

8. AGE: Years **65** Months **2** Days **3** If less than one day hr. min.

9. Birthplace **Near Marshfield, Missouri** (City, town, or county) (State or foreign country)

10. Usual occupation **Telegraph Dep't. R. R.**

11. Industry or business

12. Name **Poke Atkinson**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Fannie Atkinson**

(b) Address **Route 3, Mansfield, Missouri**

17. (a) **Burial** (b) Date thereof **7-10-45** (Month) (Day) (Year)

(c) Place: burial or cremation **Marshfield, Missouri**

18. (a) Signature of funeral director **Clinkingbeard Funeral Home**

(b) Address **Ava, Missouri**

19. (a) **July 9, 1945** (b) **S. L. Hensley** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wright**
(c) City or town **Mansfield Rural** (If outside city or town limits, write "RURAL")
(d) Street No. **Route 3** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7** year **1945** hour **5:** minute **45 P/** M.

21. I hereby certify that I attended the deceased from **June 23, 1945** to **July 7, 1945** that I last saw him alive on **July 7** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy. 15 days**
Hypertension

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **Organ**
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?

(Specify type of place) While at work? (e) Means of injury **200**
23. Signature **S. L. Hensley** (M. D. or other) **17/45**
Address **...** Date signed

PP-22-51 OCT
AUG 10 1945

SFP 27 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.....

W.B. Hutchinson

Licensed Embalmer No.

3431

P. O. Address

Am. Mod.

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.