

7. S. No. 2
DOM-5-43
Rev. 5-17-39
I X36671

FILED AUG 22 1945

Registration District No. 68

Primary Registration District No. 5268

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Christian Co

(b) City or town Galathea

(c) Name of hospital or institution: Funeral Home

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

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Christian Co

(c) City or town Galathea

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

(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 FRANCIS EISENHOWER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife C.P. Eisenhower

6. (c) Age of husband or wife if alive 7 1/8 years

7. Birth date of deceased such 16 7/1878

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>4</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace MO

(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Manual Choat

13. Birthplace Dartmouth

(City, town, or county) (State or foreign country)

14. Maiden name Frances Scott

15. Birthplace Ark

(City, town, or county) (State or foreign country)

16. (a) Informant C.P. Eisenhower

(b) Address Reeds Spring, Mo

17. (a) BURIAL (b) Date thereof 7/18/45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ponce de Leon Mo

18. (a) Signature of funeral director W. McKeon

(b) Address Reeds Spring Mo

19. (a) Aug 4 - 1945 (b) Mabel Mapes

(Date registered local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17

year 1945 hour 10:15 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 17/45

_____ 19____ to July 17/45 19____

that I last saw h. er alive on 7/17/45 19____

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 hrs

Due to high blood pressure

arterio sclerosis

Due to albuminuria

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

Major findings: _____

Of operations _____

Of autopsy g 3w

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 R.S. Shumate (M.D. or other)

Address Reeds Spring Mo Date signed 7/17/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

22
0
0

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number

845-912

Date Filed

AUG 20 1945

7/27/45

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.

BODY NOT EMBALMED

Signed.....

E. M. Jones

Licensed Embalmer No.

3453

P. O. Address

Cassville 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.