

FILED 45 22 1945

Registration District No. 45

Primary Registration District No. 5342

State File No. _____

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Dade
(b) City or town South Greenfield Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wash. Hosp. on Hwy
South Greenfield
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29
(c) City or town South Greenfield
(If outside city or town limits, write "RURAL")
(d) Street No. 16
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CALLA RADA MYERS

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 Charles A. 6. (c) Age of husband or wife if alive years
7. Birth date of deceased August 12 1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Monroe Co. Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business Home

MOTHER FATHER

12. Name Byron Hurst
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Essie Jane McDemore
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Charles A. Myers

(b) Address South Greenfield, Mo.

17. (a) Burial (b) Date thereof 18-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Daughters Cemetery

18. (a) Signature of funeral director Ray A. Jensen

(b) Address Greenfield, Mo.

19. (a) 8/14/45 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
year 1945 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from Jan 1, 1945, to Aug 13, 1945,
that I last saw her alive on Aug 9, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration
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)
(2) Means of injury _____

23. Signature J. P. Cavan (M. D. or other) _____
Address Greenfield, Mo. Date signed 8-19-45

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

RECEIVED

District Health Officer No. 6,

District File Number

845-9110

Date Filed

AUG-20-1945

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 *Sam E. Seneaney Jr*

Licensed Embalmer No. *4099*

P. O. Address *Greenfield 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.

FILED SEP 1 1945

Registration District No. 93

Primary Registration District No. 5342

Registrar's No. 6

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

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Primal Washington Ferry
(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 Calla R. Myers

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 12 (Month) (Day) (Year)

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Data received local registrar) (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 Sept day _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Cancer of uterus

Due to _____

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

Major findings: Of operations _____ Of autopsy 48W

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 8-15-45

SUPPLEMENTARY

S-27226