

FILED SEP 1945

Registration District No. 332

Primary Registration District No. 6115A

12

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Salcedo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 5 years

3. (a) PRINT FULL NAME J. C. RUNYON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Sept. 7 1933
(Month) (Day) (Year)

8. AGE: Years 11 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation School

11. Industry or business _____

12. Name Jay Runyon

13. Birthplace Blytheville Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Shelton

15. Birthplace Bennett Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Jay Runyon

(b) Address Salcedo, Route 1

17. (a) buried (b) Date thereof 6-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salcedo Mo

18. (a) Signature of funeral director John Allen

(b) Address Salcedo Mo

19. (a) Aug-22-45 (b) Mrs. Wm. J. Foster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard
(c) City or town near Salcedo, Shelton Route 1
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1945 hour 3 minute 1 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) drowning
(b) Date of occurrence June 9, 1945
(c) Where did injury occur? near Salcedo, Stoddard, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, or farm, in industrial place, in public place?
1 mile 3/4 from home
While at work? swimming (Specify type of place) Means of injury drowning

23. Signature C. G. Crank (P. of Other) 3
Address Depler Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1131

(Licensed Embalmer's Statement on Reverse Side)

June 9, 1945

RECEIVED

District Health Office No. 2

District-File Number 945-298

Date Filed 9-5-45

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.

Signed John Allerton.....

Licensed Embalmer No. 2941.....

P. O. Address Bellevue Wash.....

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.