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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30423

Registration District No. 9B

Primary Registration District No. 5345

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Rural; Sac Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: North East of Arcola
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No
(Specify whether)
In this community 64 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29

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

(d) Street No. North East of Arcola
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

3. (a) PRINT FULL NAME THOMAS L. ACHORD

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Sina achord

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased December (Month) 16 (Day) 1880 (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 12
year 1945 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from Sept. 12, 1945 to Sept. 12, 1945
that I last saw h[illegible] alive on Sept. 12, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	10 hrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations — Of autopsy —	

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE:	Years	Months	Days	If less than one day
	64	8	27	hr. min.

9. Birthplace Dade County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

MOTHER / FATHER

12. Name Samuel achord

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

14. Maiden name Susan Underwood

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

16. (a) Informant Mrs Dorothy Swafford

(b) Address Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45 (Month) (Day) (Year)

(c) Place: burial or cremation Omer Cemetery

18. (a) Signature of funeral director Sam L. Lemasters Jr.

(b) Address Trenfield, Mo.

19. (a) [illegible] (Date received by local registrar) (b) [illegible] (Registrar's signature)

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)

While at work? (Specify type of place) (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address Stoyestown Mo. Date signed 9-14-45

9-16-45 1420 (Licensed Embalmer's Statement on Reverse Side)

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. Sweeney 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.