

FILED OCT 9 1945

Primary Registration District No. 4412

1. PLACE OF DEATH

(a) County Pike
(b) City or town Corryville
(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)
In this community.

3. (a) PRINT FULL NAME SARAH ELIZABETH ATKINSON

3. (b) If veteran, name war X 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married widowed

6. (b) Name of husband or wife Abraham Atkinson 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Sept. 12 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Pike Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name George W. Williams

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

14. Maiden name Eliza Jane Cheselle

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

16. (a) Informant Mr. James Jackson

(b) Address Corryville, Mo.

17. (a) Buried (b) Date thereof 9 23 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green, Mo.

18. (a) Signature of funeral director Ward B. Bantchead

(b) Address Bowling Green, Mo.

19. (a) Sept. 25, 1945 (b) J. Bill Robinson
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike
(c) City or town Corryville
(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 Sept day 21
year 1945 hour minute 1 P M.

21. I hereby certify that I attended the deceased from Jan 2
1940 to Sept. 21 1945
that I last saw her alive on Sept. 17 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage.

Due to Hypertension disease.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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

23. Signature Eugene Harrison (M. D. or other)

Address Bowling Green, Mo. Date signed 9/20/45

(Licensed Embalmer's Statement on Reverse Side)

1600

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

OCT 10 1945

RECEIVED

District Health Officer No. 10

District File Number 10-45-1505

Date Filed OCT. 8 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

Grace Bankhead

Licensed Embalmer No.

2864

P. O. Address

Bowling Green, 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.