

FILED NOV 8 1945

Registration District No. 20

Primary Registration District No. 5081

1. PLACE OF DEATH:

(a) County Bates  
 (b) City or town Rural-East Boone Twp.  
(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 75 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Amos Wilson Heath

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

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Rosetta Heath  
 6. (c) Age of husband or wife if alive 80 years  
 7. Birth date of deceased December II 1855  
(Month) (Day) (Year)

8. AGE: Years 89 Months 10 Days 11  
 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name John C. Heath Alexander  
 13. Birthplace Not Known  
(City, town, or county) (State or foreign country)  
 14. Maiden name Alexander  
 15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant Rosetta Heath  
 (b) Address Adrian Mo

17. (a) Burial (b) Date thereof 10-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Crescent Hill Cem.

18. (a) Signature of funeral director Heath & Dix  
 (b) Address Adrian Mo

19. (a) 10-24-45 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates  
 (c) City or town Rural-East Boone Twp.  
(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 October day 22  
 year 1945 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct. 22  
 1945 to Oct. 22, 1945  
 that I last saw him dead on Oct. 22, 45, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death dead when I arrived. Possibly heart. Nothing of suspicious nature. Duration \_\_\_\_\_  
 Due to \_\_\_\_\_

Due to \_\_\_\_\_  
 Other conditions ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
 Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
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 E. E. Robinson (M. D. or other) \_\_\_\_\_  
 Address Adrian, Mo. Date signed 10-24-45

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

8-43  
-17-39  
X37823

RECEIVED

District Health Officer No. 7

Licenses Number 10-43-1048

Date Filed 11-7-43

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

*Fred T. Creath*

Registered Apprentice No.

working under my personal supervision.

Signed

*Fred T. Creath*

Licensed Embalmer No.

3343

P. O. Address

*Edman, W*

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.

Registration District No. 20 Primary Registration District No. 5081

1. PLACE OF DEATH:  
(a) County Bates  
(b) City or town Rural E. Booneburg  
(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.....  
In this community.....  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ames W. Heath  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years 89 Months 10 Days..... Unless than one day..... min.

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

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..... (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

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

19. (a)..... (b)..... (Date 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 Oct Day 2 year 1945 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... 19.....  
that I have seen him/her live on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death possibly Coronary  
Duration.....

Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)  
ADDITIONAL INFORMATION REQUESTED  
Major findings:  
Of operations.....  
Of autopsy.....  
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 E. E. Robinson (M. D. or other)  
Address Adrian, Mo. Date signed 11-12-45

SUPPLEMENTARY

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

33051