S. No. 2
M—8-43
. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 18 1945

State File No. 34067

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 40

1. PLACE OF DEATH

(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 116 Franklin
(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) 2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette
(c) City or town Lexington
(If outside city or town limits, write "RURAL")
(d) Street No. 116 Franklin
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALFRED AMOR
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased April (Month) 29 (Day) 1869 (Year)

8. AGE: Years 76 Months 3 Days 4 If less than one day hr. min.

9. Birthplace England (City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business

MOTHER FATHER
12. Name Alfred Amor
13. Birthplace England (City, town, or county) (State or foreign country)
14. Maiden name Susan Weston
15. Birthplace England (City, town, or county) (State or foreign country)

16. (a) Informant Tom Amor
(b) Address Lexington, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield Ohio
18. (c) Signature of funeral director Parrish & Tunnell
(b) Address Lexington, Mo
19. (a) Oct 1 45 (Date received local registrar) (b) Mrs Fred Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3 year 1945 hour 4 minute 15 A M.
21. I hereby certify that I attended the deceased from —, 19—, to —, 19—; that I last saw h— alive on —, 19—; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Congestive heart failure	
Acute exacerbation H.B.P.	
Chronic myocarditis	
Due to Decompensation.	
Due to Arteriosclerosis	
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.

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 [illegible] (M. D. or other)
Address Lexington Mo Date signed 8/4/45

115 8 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number
Case Filed 10-17-45

OCT 19 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 W. M. Cream

Licensed Embalmer No. 2983

P. O. Address Lexington 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.