

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 272

Primary Registration District No. 4397

Registrar's No. 910

1. PLACE OF DEATH

(a) County Commissat
(b) City or town Coaster
(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 none
(Specify whether

In this community 1 day
years, months or days)

3. (a) PRINT FULL NAME Willis Lynn Hand Jr.

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 Single

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

7. Birth date of deceased Sept 5 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 1 hr. min.

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

10. Usual occupation cell

11. Industry or business _____

12. Name Willis L Hand Sr.
13. Birthplace Bradford NY (City, town, or county) (State or foreign country)
14. Maiden name Anna Maude Ester
15. Birthplace Harnersville MO (City, town, or county) (State or foreign country)

16. (a) Informant Willis L Hand
(b) Address Coaster

17. (a) Burial (b) Date hereof 9-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Pone

(b) Address _____

19. (a) 10-30-45 (b) S. L. Gehlman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Commissat
(c) City or town Coaster
(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 9 day 5
year 1945 hour 9 minute 3 A.M.

21. I hereby certify that I attended the deceased from 9 4 1945 to 9-5-1945
that I last saw him alive on 9 4 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Syphilis
Duration _____

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.

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 P. E. Cooper (M. D. or other) M.D.
Address Coaster, Mo. Date signed 9-17-45

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

MOTHER FATHER

10-45-197

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.