

FILED NOV 1 1945

Registration District No. **3A-9**

Primary Registration District No. **4526**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vernon
 (b) City or town Sheldon
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Home - Sheldon Mo
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME ARTHUR GILBERT ALTHAM

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced m /
 6. (b) Name of husband or wife Ethel Pearl Altham 6. (c) Age of husband or wife if alive 55 years
 7. Birth date of deceased Aug 19, 1879
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Physician

11. Industry or business Same

MOTHER FATHER } 12. Name William Altham
 13. Birthplace Brunley England
(City, town, or county) (State or foreign country)
 14. Maiden name Alice Croyer
 15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. J. Altham
 (b) Address Sheldon Mo

17. (a) Burial (b) Date thereof Nov 1, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada Mo.

18. (a) Signature of funeral director A. B. Berry & Sons
 (b) Address Sheldon Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30
 year 1945 hour 5 minute 10 AM.

21. I hereby certify that I attended the deceased from Oct 1942 to Oct 30 1945
 that I last saw him alive on Oct 29 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardial insufficiency
 Due to Coronary sclerosis
 Due to Arterial sclerosis

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy A

Duration _____
 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 F. L. Martin (M. D. or other) M.D.
 Address Nevada Mo Date signed 12-30-45

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

0. 2
2-43
7-39
X35697

APR 11 1946

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

Carroll T. Reery

Licensed Embalmer No.

2385

P. O. Address

Sheldon 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.

Registration District No. 359

Primary Registration District No. 4526

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

1. PLACE OF DEATH:

(a) County Wernan
(b) City or town Sheldon
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Arthur G. Altham

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 m

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

7. Birth date of deceased Aug 1 1945
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days _____ (If less than one day) hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 Nov. 1, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 30, 1945 (b) Paula Faith
(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 _____ Day 30 Year 1945 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

APR 11 1946

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