

FILED NOV 1 1945
Registration District No. **359**

Primary Registration District No. **6220**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Vernon**
 (b) City or town **Garland (Rural) Harrison Township**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2 Mi S.E. Garland, Kansas
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **40 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Vernon**
 (c) City or town **Garland (Rural) Harrison Township**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2 Mi S. E. Garland, Kansas**
(If rural, give location)
 (e) Citizen of foreign country? _____
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Roy G. Ewing**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **3**
 year **1945** hour **1** minute **PM** M.

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Vern Walker** Age of husband or wife if alive **44** years

21. I hereby certify that I attended the deceased from
Sept. 30, 19 **45** to **Oct. 3**, 19 **45**.
 and that death occurred on the date and hour stated above.
 that I last saw him alive on **Oct. 2 - 1945**

7. Birth date of deceased: **July 5, 1902**
(Month) (Day) (Year)
8. AGE: Years **43** Months **2** Days **28**
 If less than one day hr. _____ min. _____

Immediate cause of death **Chronic Endocarditis** Duration
and Mitral Insufficiency,
probably of a few years duration.
 Due to **D.K.**

9. Birthplace **Adama, Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**

Due to _____
 Other conditions (Include pregnancy within 3 months of death) **g2d**

11. Industry or business _____
12. Name **No record**
13. Birthplace **No record**
(City, town, or county) (State or foreign country)
14. Maiden name **No record**
15. Birthplace **No record**
(City, town, or county) (State or foreign country)

Major findings:
 Of operations **No operation**
 Of autopsy **No autopsy.**
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Vern Ewing**
(b) Address **Vernon County, Missouri**
17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** _____
(Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director **Konantz Mortuary**
(b) Address **Fort Scott, Kansas**
19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

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? _____ (b) Means of injury _____
23. Signature **F. C. Albright** (M. D. or other)
 Address **Garland, Kans.** Date signed _____

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

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 _____

Licensed Embalmer No. 2087

P. O. Address H. Scott, N.Y.

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. 6220

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Hamisontup
(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

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 _____

3. (a) PRINT FULL NAME Roy G. Ewing

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 _____ years

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

8. AGE: Years 43 Months 2 Days _____ (Less than one day)

hr. _____ min.

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

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) (Burial, cremation, or removal) _____ (b) Date thereof 10 8 45
(Month) (Day) (Year)

(c) Place: burial or cremation Sweedy. Cem.

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 10, 1945 (b) Ruth Faith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 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 _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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