

Registration District No. **134**

Primary Registration District No. **5493**

Registrar's No.

1. PLACE OF DEATH:

(a) County **HARRISON**  
(b) City or town **RURAL FOX CREEK TWP.**  
(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 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **HARRISON**  
(c) City or town **RURAL**  
(d) Street No. **FOX CREEK TWP.**  
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **ROY CHESTER CABLE**

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 **MARRIED**

6. (b) Name of husband or wife **MINNIE** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased (Month) **2** (Day) **21** (Year) **1885**

8. AGE:	Years	Months	Days	If less than one day
	<b>60</b>	<b>7</b>	<b>11</b>	hr. min.

9. Birthplace **ILLINOIS!**

10. Usual occupation **FARMING**

11. Industry or business **AGRICULTURE**

12. Name **EDWARD CABLE**

13. Birthplace **ILLINOIS!**

14. Maiden name **SARAH PEARSON**

15. Birthplace **ILLINOIS!**

16. (a) Informant **Minnie Cable**

(b) Address **Shuman City, Mo.**

17. (a) **BURIAL** (b) Date thereof **10/7/45**

(c) Place: burial or cremation **Shuman City, Mo.**

18. (a) Signature of funeral director **S. M. Shaw**

(b) Address **Shuman City, Mo.**

19. (a) **Nov. 7-45** (b) **S. P. Shaw**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER**, day **2**  
year **1945** hour **5** minute **30** P.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.

Immediate cause of death \_\_\_\_\_

**Apoplexy**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **g3w**

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 **Joe E. Wheeler** (M. D. or other)

Address **Shuman City, Mo.** Date signed **10/7/45**

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

11  
0  
0

1945

*S. P. ...*

RECEIVED  
District Health Officer No. 111  
District File Number  
Date Filed

DEC 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 *Thomson H. Haas*

Licensed Embalmer No. *2861*

P. O. Address *Bethany, 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.