

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

1. PLACE OF DEATH:
 (a) County JACKSON
 (b) City or town INDEPENDENCE
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1319 W. VAN HORN /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 38 YEARS
(Specify whether years, months or days)
 In this community 38 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County JACKSON 47
 (c) City or town INDEPENDENCE 7
(If outside city or town limits, write "RURAL")
 (d) Street No. 1319 W. VAN HORN
(If rural, give location)
 (e) Citizen of foreign country? NO 11
(Yes or No)
 If yes, name country _____

3. (a) PRINT DR. WILLIAM E. MESSENGER
FULL NAME

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

4. Sex MALE 0
WHITE
 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ANNA H. MESSENGER
 6. (c) Age of husband or wife if alive 1862 years

7. Birth date of deceased 10 10 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 7
 If less than one day hr. _____ min.

9. Birthplace DANVILLE IOWA /
(City, town, or county) (State or foreign country)

10. Usual occupation PHYSICIAN

11. Industry or business MEDICAL DOCTOR

12. Name HYRUM E. MESSENGER

13. Birthplace NO RECORD 9

14. Maiden name ANNAR SCOTT (State or foreign country)

15. Birthplace NO RECORD 4

16. (a) Informant MISS DRUSILLA MESSENGER

(b) Address 1319 W. VAN HORN

17. (a) BURIAL (b) Date thereof 11-19-45

(c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director James W. Stahl

(b) Address 815 W. MAPLE AVE.

19. (a) 11-19-45 (b) James W. Stahl

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17
 year 1945 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1 Nov
1945 to 17 Nov 1945
 that I last saw him alive on 15 Nov 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 1628 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 W. Saunders (M. D. or other) MD

Address Indep Mo Date signed 19 Nov 45

MAY 21 1945

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 Henry W. Stahl
Licensed Embalmer No. 3181
P. O. Address Independence

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.