

No. 2
-5-43
-5-17-39
X36671

FILED JAN 8 1946

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 356

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Bothwell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)

In this community 41 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis 80

(c) City or town Sedalia 6
(If outside city or town limits, write "RURAL")

(d) Street No. Main St. & State Fair Blvd. 4
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country _____

3. (a) PRINT FULL NAME George B. Hosford

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec day 19 year 1945 hour 8 minute a M.

21. I hereby certify that I attended the deceased from Nov 15 to Dec 19 1945 that I last saw him alive on Dec 18 and that death occurred on the date and hour stated above.

4. Sex Male d 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Hamilton Hosford

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased December 25 1865
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis

Due to _____

Due to _____

8. AGE: Years Months Days If less than one day

79 11 24 hr. min.

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

10. Usual occupation Retired Pipe Fitter Foreman

Other conditions Fracture Rt Femur 2 wks
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name Byron W. Hosford

13. Birthplace Gallion Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Schull

15. Birthplace Gallion Ohio
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

16. (a) Informant William C. Hosford

(b) Address Sedalia, Missouri

17. (a) Burial (b) Date thereof Dec. 22, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director McLaughlin Bros.

(b) Address Sedalia, Missouri

19. (a) 12-28-45 (b) A. J. Campbell
(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) Resident 132

(b) Date of occurrence Dec 3 1945

(c) Where did it occur? Sedalia, Pettis Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home

While at work? no (Specify type of place) _____

(e) Means of injury _____

23. Signature Dr. J. B. ... (M. D. or D. O.) MO

Address 12/21/45 Date signed Sedalia, Mo

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-7-46

JAN 10 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.....

Licensed Embalmer No. 3153

P. O. Address Dedalia, 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. 274

Primary Registration District No. 3052

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1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME George B. Hoopad
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 Dec 25, 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 27 If less than one day _____ hr. _____ min.

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

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. (c) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ Year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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 1860 18

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence Dec 3, 1943
(c) Where did injury occur? Her home Sedalia Pettis Mo
(City, town) (County) (State)
(d) Did injury occur in or about home, or farm, in industrial place, in public place?
Her home
While at work? _____ (Specify type of place) _____ (e) Means of death slipped on floor
23. Signature W. B. Besterman (M. D. or other) _____
Address Sedalia Mo Date signed 1/24/46

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

42089