

**FILED** JAN 25 1948

Registration District No. 221

Primary Registration District No. 4314

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Atlanta  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Fred A. Atterberry

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 4

1882  
(Month) (Day) (Year)

8. AGE:

Years 63 Months 3 Days 18  
If less than one day hr. min.

9. Birthplace

Macon Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation

Retired Mail Carrier

11. Industry or business

12. Name Philander Atterberry  
13. Birthplace Macon Co. Mo  
14. Maiden name Martha Farmer  
15. Birthplace Macon Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant

Hannie Newmyer

(b) Address

Macon Mo

17. (a) Burial

(b) Date thereof 12-26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Mt. Taber Macon Co. Mo

18. (a) Signature of funeral director

Stephen & Gooding

(b) Address

Macon Mo

19. (a) 12-27-45

(b) M. O. Griffin  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon 61  
(c) City or town Atlanta  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no (If No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22nd  
year 1945 hour 5 minute 00 P.M.

21. I hereby certify that I attended the deceased from Dec 15, 1945, to Dec 22, 1945  
that I last saw him alive on Dec 22  
and that death occurred on the date and hour stated above

Immediate cause of death Angina Pectoris  
Arterio Sclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations 940

Of autopsy None

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?  
(Specify type of place)  
While at work? (e) Means of injury

23. Signature A. J. Cramble (M. D. or other)

Address Atlanta Ga Date signed

146

(Licensed Embalmer's Statement on Reverse Side)

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

100370

JAN 20 1946

RECEIVED  
Office of Health Officer  
District No. 1-46-2B  
Date Recd. JAN 22 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.....

*This Embalming*

working under my personal supervision.

Registered Apprentice No. *3982*

Signed.....

*C. L. Stephens*

Licensed Embalmer No. *3057*

P. O. Address: *Macon, 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.