

FILED APR 10 1946

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(c) Name of hospital or institution Lee Hospital
(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)

3. (a) PRINT FULL NAME JERRY CARROLL ANGELL

3. (b) If veteran, name was none 3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 7 years
7. Birth date of deceased Mar 23 - 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
— — 1 hr. min.

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

10. Usual occupation Infant

11. Industry or business

12. Name Carl Angell
13. Birthplace Randolph MO.
(City, town, or county) (State or foreign country)
14. Maiden name Marie Louise Switzer
15. Birthplace Randolph MO.
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Angell

(b) Address Clayton MO.

17. (a) Burial (b) Date thereof Mar 25 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapel Grove

18. (a) Signature of funeral director Edgar Funeral Home

(b) Address Merberly MO.

19. (a) 3 - 28 - 1946 (b) Dr. J. J. Shaw
(Date received local registrar) (Physician's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. none
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1946 hour 7 minute 45 A.M.
21. I hereby certify that I attended the deceased from 3 - 23
1946 to 3 - 24, 1946
that I last saw him alive on 3 - 24, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (2 months)
Due to Premature separation of maternal membranes
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none 159
Of autopsy none
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) (c) Means of injury
23. Signature Dr. J. J. Shaw (M. D. or other) MD
Address Fayette, MO. Date signed 3-27-46

RECEIVED

Print Name of Deceased No. 8.

Print File Number #

Date Filed 4-10-46

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.

*Infant
Not Embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.