

No. 2
1-5-43
5-17-39
I X3687

FILED MAY 16 1946

Registration District No. _____ Primary Registration District No. 3041

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Macon

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? yes no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME James Greathouse

3. (b) If veteran name war _____ **3. (c) Social Security** No. _____

4. Sex Male **5. Color or race** White

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

6. (b) Name of husband or wife Samuel Greathouse **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Local Missor

12. Name John Greathouse

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

14. Maiden name Mabel Nelson

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

16. (a) Informant Mrs James Greathouse

(b) Address Macon MO

17. (a) Burial, cremation, or removal Burial **(b) Date thereof** 5-7-46
(Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director Albert Spanier

(b) Address Macon MO

19. (a) Date received by local registrar May 8-1946 **(b) Registrar's signature** Alfred McNeely

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
year 1946 hour 4-730 minute 12 M.

21. I hereby certify that I attended the deceased from 3/28/46
5 19____ to 5-5-46 1946

that I last saw him alive on 5-5-46 and that death occurred on the date and hour stated above

Immediate cause of death Cerebral Hemorrhage Duration 4 days

Due to arterio sclerosis 3 yrs

Due to _____

Other conditions None of note
(Include pregnancy within 3 months of death)

Major findings: none

Of operations _____

Of autopsy NO autopsy

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) no

(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? yes

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. E. C. M. D. (M. D. or other)

Address Macon MO Date signed 5-7-46

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

MOTHER FATHER

185

MAY 16 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.....

Albert Skinner

Licensed Embalmer No.....

757

P. O. Address.....

Mason 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.