

FILED JUN 20 1948

Primary Registration District No. **45-13**

Registrar's No. **10**

1. PLACE OF DEATH

(a) County *Sullivan*
(b) City or town *Green Castle*
(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 *1*
In this community *Life* years, months or days (Specify whether)

3. (a) PRINT FULL NAME

BERT CHRISMAN

3. (b) If veteran, name war *✓*

3. (c) Social Security No. *✓*

4. Sex *MALE*

5. Color or race *W*

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

6. (b) Name of husband or wife *Mollie Richardson*

6. (c) Age of husband or wife if alive *4* years

7. Birth date of deceased *7* (Month) *4* (Day) *1883* (Year)

8. AGE: Years *62* Months *9* Days *9* If less than one day hr. min.

9. Birthplace *Grundey Co. Mo. 11* (City, town, or county) (State or foreign country)

10. Usual occupation *P.R.*

11. Industry or business *Work in Round House*

12. Name *Airam Chrisman*

13. Birthplace *Don't know* (City, town, or county) (State or foreign country)

14. Maiden name *Sarah Ellis*

15. Birthplace *Don't know* (City, town, or county) (State or foreign country)

16. (a) Informant *Lillie Heduck*

(b) Address *Green Castle, Mo.*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *5 15-46* (Month) (Day) (Year)

(c) Place: burial or cremation *Green Castle Cem.*

18. (a) Signature of funeral director *Henry E. Kent & Son*

(b) Address *Green Castle, Mo.*

19. (a) *June 3-1946* (Date received local registrar) (b) *Paula Shaw-Spitzer* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Sullivan* *105*
(c) City or town *Green Castle* *1*
(If outside city or town limits, write "RURAL")
(d) Street No. *1* (If rural, give location)
(e) Citizen of foreign country? *No.* (Yes or No)
If yes, name country *✓*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *MAY* day *13* year *1946* hour *3:30* minute *19* M.

21. I hereby certify that I attended the deceased from *April 27*, 19*46*, to *MAY 13*, 19*46* that I last saw him alive on *MAY 12*, 19*46* and that death occurred on the day and hour stated above.

Immediate cause of death *Passive PULMONARY CONGESTION*

Due to *Chronic Bronchial ASTHMA*

Due to *Cerebral Hemorrhage*

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy *(B)*

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 *2*

23. Signature *M. B. Dehner* (M. D. or other) Address *Green City, Mo.* Date signed *5-13-46*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

18087

RECEIVED

District Health Officer No. 10

District File Number 6-46-1118

Date Filed JUN 6 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.