

FILED AUG 19 1946 **STANDARD CERTIFICATE OF DEATH**
State File No. **26153**Registration District No. **1**Primary Registration District No. **3000**Registrar's No. **223****1. PLACE OF DEATH:**

(a) County **Adair**
 (b) City or town **Kirkville**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Laughlin Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Hospital**
 (Specify whether years, months or days)
 In this community **7 Days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **Monroe** **949**
 (c) City or town **Moravia R.F.D.** **13**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **8**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) **2**
 If yes, name country.

3. (a) PRINT FULL NAME **Harry D. Tissue**

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

4. Sex **Male** 0 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Carrie** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **Jan. 20 1885**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 6 9 hr. min.

9. Birthplace **Appanoose Co. Iowa**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farm**

12. Name **M. B. Tissue**

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

14. Maiden name **Mary Ellen Jones**

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

16. (a) Informant **Carrie Tissue**

(b) Address **Moravia Iowa**

17. (a) **Removal** (b) Date thereof **July 31, 1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Moravia Cem.**

18. (a) Signature of funeral director **S. E. Kelley**

(b) Address **Kirkville, Mo**

19. (a) **8-6-46** (b) **W. L. Lambert**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29**
 year **1946** hour **3** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **July 22**, 19**46** to **July 29**, 19**46**, that I last saw **survive** on **July 29**, 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death: **Pulmonary embolus at lung**

Due to **137B**

Major findings: **Supra pubic protuberance by excoriation**
 Of operations **#**
 Of autopsy

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) _____ (2) Means of injury **2**
 23. Signature **Earl Laughlin** (M. D. or other) **D.O.**
 Address **Kirkville, Mo** Date signed **8-6-46**

JUN 3 1947
MAY 23 1947

RECEIVED
District Health Officer No. 10
District File Number 8-46-1545
Date Filed AUG 14 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..... *J. E. Riley*

Licensed Embalmer No. *4181*

P. O. Address *Kirkville, 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. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(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 Harry D. Tisue
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 Jan 20
(Month) (Day) (Year)

8. AGE: Years 61 Months _____ Days _____ (If less than one day) _____ hr. _____ min.

9. Birthplace _____ (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. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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 July year 1946 hour _____ minute _____ M. 29
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; 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 _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
137A

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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

24993 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

