

(Licensed Embalmer's Statement on Reverse Side)

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 46-1867-
Date Filed OCT 31 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 Glenn E. Kent

Licensed Embalmer No. 1769

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Nov*

Registration District No. *349*

Primary Registration District No. *4513*

Registrar's No. *17*

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:

(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

Albert E. Bishop

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, months, days. *19*

7. Birth date of deceased. (Month) *June* (Day) *19* (Year) *1946*

8. AGE: Years *42* Months *2* Days *22* If less than one day, hr. min.

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

10. Usual occupation.

11. Industry or business.

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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) *10-22-46* (b) *Laura M. Shaw* (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 *June* year *1946* hour *2* minute *15* M.

21. I hereby certify that I attended the deceased from *June 19, 1946* to *June 22, 1946*, 19 *1946*; that I last saw him alive on *June 22, 1946* 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.

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. (M. D. or other)

Address. Date signed.

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

SUPPLEMENTARY

35862