

**FILED DEC 11 1946**Registration District No. **271**Primary Registration District No. **597-4401**Registrar's No. **17**

## 1. PLACE OF DEATH:

(a) County **Pemiscott**  
(b) City or town **Pascola**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Pascola Mo.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3yrs.** (Specify whether  
In this community  
years, months or days)

3. (a) PRINT  
FULL NAME**Grady J. Ables**3. (b) If veteran,  
name war3. (c) Social Security  
No.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married,  
divorced **Single**  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased **Mar 12 1900**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**46 4 2**  
hr. min.

9. Birthplace **Reelfoot Tenn.**  
(City, town, or county) (State or foreign country)10. Usual occupation **Farming**

11. Industry or business

MOTHER FATHER { 12. Name **J.M. Ables**  
13. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Willie Spicer**  
15. Birthplace **Waverly Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Willie H. Spicer**  
(b) Address **Pascola Mo.**17. (a) **Burial** (b) Date thereof **11-17-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Blytheville Ark.**18. (a) Signature of funeral director **Bob Turner**  
(b) Address **Blytheville Ark.**19. (a) **11-27-46** (b) **Mrs. Jessie Turney**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Ark.** (b) County **Miss.** **997**  
(c) City or town **Pascola Mo.**  
(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 **14** day **Nov.** 1946  
year **3 P.** hour minute M.

21. I hereby certify that I attended the deceased from  
**9-12-46** 19\_\_\_\_ to **10-14-46** 19\_\_\_\_  
that I last saw him alive on **11-7-46**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Pneumonia**  
Duration

Due to  
Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED**

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?

(Specify type of place)  
(e) Means of injury  
23. Signature **J. Mastero** (M.D. or other)  
Address **Dayton Mo.** Date signed **11-20-46**

12-46-253

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.....

*myself*

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Jas. R. Starnall*

Licensed Embalmer No. *3100*

P. O. Address

*Blythenville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above:

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 271

Primary Registration District No. 4801

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Pemiscott  
(b) City or town Pascala  
(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

Shady J. Ahler

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 s

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

7. Birth date of deceased mar 12 1930 (Month) (Day) (Year)

8. AGE: Years 46 Months 4 Days 1 If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name { 13. Birthplace (City, town, or county) (State or foreign country) 14. Maiden name (City, town, or county) (State or foreign country) 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) (Date received local registrar) (b) (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 mar year 1946 hour 10 minute 06 M.

21. I hereby certify that I attended the deceased from to

that I last saw him alive on

and that death occurred on the date and hour stated above.

Immediate cause of death

lobar pneumonia

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) (e) Means of injury

23. Signature J. H. Masters M. D. (Physician)

Address Date signed

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

36680

37863