

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural - Atlas 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 None
(Specify whether years, months or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Worth 113
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH A. CANADAY

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 widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Oct 7 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Leitch Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Robert Canaday
13. Birthplace Ind 1
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Farris
15. Birthplace Ind 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Elsie Harmon
(b) Address Worth MO
17. (a) Burial (b) Date thereof Jan 20 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation prairie chard country
18. (a) Signature of funeral director Paul Bros
(b) Address Denver MO
19. (a) Feb 12 1947 (b) Letta E. Dawson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18
year 1947 hour 3 minute 0 P. M.

21. I hereby certify that I attended the deceased from Jan 1 1947 to Jan 18 1947
that I last saw him alive on Jan 18 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Labor Pneumonia
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

Duration 3 day

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) Means of injury 2
23. Signature Charles D. Williamson (M. D. or other) MO
Address Worth Date signed 2-1-47

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. P. Brown

Licensed Embalmer No. *297*

P. O. Address. *Dennis, 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.