

U.S. No. 2  
FORM-8-43  
Rev. 5-17-39  
1 X37823

**FILED APR 9 1947**

Registration District No. **41**

Primary Registration District No. **3008**

**1. PLACE OF DEATH:**

(a) County Callaway

(b) City or town Hulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 364 2nd 2  
(Specify whether years, months or days)

In this community same

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Call 14

(c) City or town Jefferson City 2  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** THOMAS TATTERSHALL

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MD 5. Color or race W 6. (a) Single, widowed, married, divorced SO

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

7. Birth date of deceased 1881  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 31 year 1947 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from 3/27, 1947, to 3/31, 1947  
that I last saw him alive on 3/31, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia 4d

Duration \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>66</u>			hr. _____ min. _____

9. Birthplace Champaign Ill 1  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business farmer

MOTHER FATHER { 12. Name dk

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

14. Maiden name dk

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

16. (a) Informant Hospital records

(b) Address Hulton Mo

17. (a) Removal (b) Date thereof 4 1 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Mo

18. (a) Signature of funeral director J. B. Robert

(b) Address Columbia Mo

19. (a) 4-1-1947 (b) Joan Moskoff  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 107

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 0

23. Signature J. Caldwell (M. D. or other) MD

Address Hulton Mo Date signed 3/31/47

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

14  
25

Date Filed 7-8-47  
District File Number

District Health Officer No. 9,

RECEIVED

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.