

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8461
Registrar's No. 8

Registration District No. 99

Primary Registration District No. 4167

1. PLACE OF DEATH:

(a) County De Kalb.
(b) City or town Amity
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution home.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution home.
30 years. (Specify whether years, months or days)
In this community 30 years.

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

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

4. Sex male. 5. Color or race white. 6. (a) Single, widowed, married, divorced widow.
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 17 years (Month) (Day) (Year)
7. Birth date of deceased Jan 17 1863 (Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 8 If less than one day hr. min.

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

10. Usual occupation Farmer.

11. Industry or business

12. Name Joseph Quarles.
13. Birthplace Va (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Conditon
15. Birthplace Va (City, town, or county) (State or foreign country)

16. (a) Informant Mr. C. C. Allhouse
(b) Address Amity Mo.

17. (a) Burial. Date thereof 3-26-47 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Amity Mo.

18. (a) Signature of funeral director John Bram
(b) Address Mayfield Mo.

19. (a) 325-47 (Date received local registrar) (b) A. Harrison (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County De Kalb.
(c) City or town Amity (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25 year 1947 hour 3 minute 20 A.M.

21. I hereby certify that I attended the deceased from Sept 1944 to March 25, 1947
that I last saw him alive on March 24, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis [4th attack in 5 years] Duration 10 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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?

(Specify type of place) While at work? (e) Means of injury 2

23. Signature Harold Fowler (M. D. or other) D.O.

Address Mayfield Mo Date signed 3-25-47

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

John Brown

Licensed Embalmer No.

3935

P. O. Address

Mayville

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.