

FILED AUG 7 1947

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 278

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:
State Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mo. 4 days
(Specify whether years, months or days)

In this community 4 mo. 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain

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

(d) Street No. East Main
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME FRANKIE BYARS

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

4. Sex Female 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 March OK 1882
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1947 hour 11:00 minute A M.

21. I hereby certify that I attended the deceased from March
27, 1946, to July 31, 1947;
that I last saw him alive on July 30, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis pneumonia

Duration 3 days

8. AGE: Years Months Days If less than one day

65 4 ? hr. _____ min.

Due to _____

Due to _____

9. Birthplace Audrain Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Cleaning & Pressing

11. Industry or business _____

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

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name Jim Hall

13. Birthplace Merion Missouri
(City, town, or county) (State or foreign country)

14. Maiden name OK

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant State Hospital No. 1, Merion
(b) Address Fulton, Missouri

17. (a) BURIAL (b) Date thereof Aug 2, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cem

18. (a) Signature of funeral director W. W. H. H. H.
(b) Address Merion, Mo.

19. (a) July 31-47 (b) John M. M. M.
(Date received local registrar) (Registrar's signature)

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 D. R. P. Price (M. D. or other)
W. W. H. H. H.
Address State Hospital No. 1 Date signed Aug 31, 1947

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

14
1
2

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 8-6-47

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 Emerett R. Head
Licensed Embalmer No. 4038
P. O. Address Mexico, 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.