

FILED AUG 12 1947

Registration District No. 349

Primary Registration District No. 4514

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Green City  
(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 Life years, months or days)

3. (a) PRINT FULL NAME George Washington Tally

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 m

6. (b) Name of husband or wife Catherine Tally 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Feb 14 1863 (Month) (Day) (Year)

8. AGE: Years 84 Months 5 Days 18 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Henry Tally '9

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

14. Maiden name Susan Baldrige

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

16. (a) Informant Mrs. Marie Robertson

(b) Address Green City

17. (a) Burial (b) Date thereof 8-2-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cem.

18. (a) Signature of funeral director (b) Address Green City Mo

19. (a) 8-7-47 (b) (Date received local registrar) (Registrar's signature) Taura Shaw

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105  
(c) City or town Green City (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 8 day 2 year 1947 hour 2:30 minute A.M.

21. I hereby certify that I attended the deceased from Feb 10 1940 to Aug 2 1947 that I last saw him alive on Aug 2 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Valvular disease of the Heart Duration

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?

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

23. Signature M. H. ... M.D. (M. D. or other)

Address Green City Mo Date signed 8-2-47

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

500

RECEIVED  
District Health Officer No. 10  
Waist File Number 8-47-1043  
Date Filed AUG 11 1947

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Greenleaf, 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.