

S. No. 2
M-5-43
5-17-39
I X36871

FILED AUG 25 1947

Registration District No. _____

Primary Registration District No. **4411**

Registrar's No. **328**

1. PLACE OF DEATH:

(a) County **Pike**

(b) City or town **Bowling Green**
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pike** **82**

(c) City or town **Clarksville**
(If outside city or town limits, write "RURAL") **0**

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? _____ (Yes or No) **0**

If yes, name country _____

3. (a) PRINT FULL NAME **Ella Malvina Wamsley**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **3** year **1947** hour **2** minute **6** M.

21. I hereby certify that I attended the deceased from _____ 19**47** to **8/3** 19**47** that I last saw him alive on **8/2** 19**47** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John Wamsley**

6. (c) Age of husband or wife if alive **90** years

7. Birth date of deceased **Sept 7 1860**
(Month) (Day) (Year)

Immediate cause of death **Cardiac Reconversion** Duration **37 hrs**

8. AGE:	Years	Months	Days	If less than one day
	86	10	24	hr. min.

Due to _____

Due to _____

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

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

10. Usual occupation **Retired**

Major findings: **RU**

Of operations _____

11. Industry or business _____

12. Name **Umar Vaughan**

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

14. Maiden name **Sarah Swain**

15. Birthplace **Dover Iowa**
(City, town or county) (State or foreign country)

16. (a) Informant **Ella Wamsley**

(b) Address **Bowling Green Mo**

17. (a) **burial** (b) Date of **Aug 4 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood**

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? _____

18. (a) Signature of funeral director **Harry S. Carroll**

(b) Address **Clarksville Mo**

19. (a) **8-16-47** (b) **Bill Robinson**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury **fall**

23. Signature **J. M. Adams** M. D. or other **vee**

Address **Bowling Green** Date signed **8/4/47**

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

RECEIVED
District Health Officer No. 10
District File Number 8-47-1094
Date Filed AUG 22 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 msw

....., Registered Apprentice No.
working under my personal supervision.

Signed Harry Carroll

Licensed Embalmer No. 7439

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.