

FILED OCT 7 1947

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 264

1. PLACE OF DEATH:

(a) County Adair

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

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

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98

(c) City or town Lancaster 0
(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 _____

3. (a) PRINT FULL NAME WILLIAM ANDERSON GRESHAM

3. (b) If veteran, name was _____

3. (c) Social Security No. _____

4. Sex Male 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
(Day) (Year)

7. Birth date of deceased: May 16 1886
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>4</u>	<u>12</u>	hr. min.

9. Birthplace New Queen city Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Blacksmith

11. Industry or business _____

12. Name W. A. Gresham

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

14. Maiden name Susan Crapan

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

16. (a) Informant Gresham

(b) Address Queen city, Mo.

17. (a) Burial (b) Date thereof 9-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jane Cemetery

18. (a) Signature of funeral director Wm G. West

(b) Address Queen city Mo.

19. (a) Sept 29-47 (b) W. G. Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1947 hour 16:30 minute 9 M.

21. I hereby certify that I attended the deceased from Sept 24 1947, to Sept 28 1947, that I last saw him alive on Sept 28 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate
9 anemia

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

51B

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 RO Stickler (M. D. or other) MD
Address Kirksonville Mo Date signed 9-29-47

Duration 2 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 10
District File Number 10-47-1348
Filed OCT - 6 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 Self
....., Registered Apprentice No.
working under my personal supervision.

Signed Wm A West
Licensed Embalmer No. 2882
P. O. Address Queens City NY

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.