

Registration District No. _____

Primary Registration District No. 5466

Registrar's No. 771

1. PLACE OF DEATH:

GREENE

(a) County _____
(b) City or town Rural - S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OTARK OSTEOPATHIC HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Summersville, Mo.
(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

Albert M. Terrill

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex Male Color or race White

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

6. (b) Name of husband or wife Rosa Terrill

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

7. Birth date of deceased Nov. 28, 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 3
If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business On Farm

MOTHER FATHER

12. Name John Terrill

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

14. Maiden name Caroline Panty

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

16. (a) Informant Rosa Terrill

(b) Address Summersville, Mo.

17. (a) Removal (b) Date thereof 8-31-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Summersville, Mo. Home

18. (a) Signature of funeral director Norman Scheff

(b) Address Springfield, Mo.

19. (a) 8-31-47 (b) W. E. Handley, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 31
year 47 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from 8-26, 1947, to 8-31, 1947.
that I last saw him alive on 8-31, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death MYOCARDIAL FAILURE

Due to CHRONIC NEPHRITIS

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)
(2) Means of injury _____

23. Signature R. A. Michael, D.D. 2
(Name in full) (Date signed) 8-31-47

Address Springfield, Mo.

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

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.....

.....
working under my personal supervision.

Signed.....
Registered Apprentice No.....
Licensed Embalmer No. *3802*
P. O. Address..... *Springfield, 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.