

FILED NOV 25 1947

Registration District No. 1947

Primary Registration District No. 4203

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Grundy  
(b) City or town Galt  
(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 \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Grundy  
(c) City or town Galt  
(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 EDWIN E. ROOT

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

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced Mar

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 15 1864  
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retail Groceries Mchnt.

11. Industry or business " "

12. Name Levin Root.

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

14. Maiden name Rachel McCombs

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

16. (a) Informant Mrs Earl Eversly

(b) Address Galt Mo

17. (a) Burial (b) Date thereof 9-23-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.P. Cem. Galt Mo

18. (a) Signature of funeral director W. C. Weston

(b) Address Galt Mo

19. (a) 9-23-47 (b) J. E. Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21  
year 1947 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from 1-1-1947 to 9-21-1947  
that I last saw him alive on 9-20-1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Due to Cystitis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 130

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 W. C. Weston (M.D. or other) MD  
Address Galt Mo Date signed 9-23-47

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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DISTRICT HEALTH OFFICE  
Cameron, Mo.

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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..... *R. H. Payne Jr* .....

Licensed Embalmer No. *3400* .....

P. O. Address..... *Salt* .....

**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.**