

FILED FEB 16 1948

Registration District No. 999

Primary Registration District No. 41-6-9-5374

Registrar's No. 8

1. PLACE OF DEATH:

(a) County: DEKALB
(b) City or town: OSBORN (RURAL)
(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: 12 YEARS (Specify whether
In this community: 12 YEARS years, months or days)

3. (a) PRINT FULL NAME: JOHN WILLIAM FILLEY

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex: MO 5. Color or race: W 6. (a) Single, widowed, married, (divorced) DIVORCED
6. (b) Name of husband or wife: IDA FILLEY 6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: NOV 2 1861 (Month) (Day) (Year)

8. AGE: Years: 86 Months: 2 Days: 19 If less than one day: _____ hr. _____ min.

9. Birthplace: CLINTON CO. MO (City, town, or county) (State or foreign country)

10. Usual occupation: FARMER

11. Industry or business: _____

MOTHER FATHER
12. Name: UNKNOWN
13. Birthplace: _____ (City, town, or county) (State or foreign country)
14. Maiden name: _____
15. Birthplace: _____ (City, town, or county) (State or foreign country)

16. (a) Informant: IDA KIRK PATRICK
(b) Address: OSBORN - MO RFD

17. (a) BURIAL (b) Date thereof: 1-24-48 (Month) (Day) (Year)
(c) Place of burial or disposition: DAK LANN, MAYSVILLE MO

18. (a) Signature of informant: _____
(b) Address: PACHER FUNERAL HOME, MAYSVILLE, MO

19. (a) 1-23-48 (Date received local registrar) (b) R. DAVIDSON (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: DEKALB 32
(c) City or town: RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No.: _____ (If rural, give location) 3
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1948 hour Five minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Irritation Duration: _____

Due to: _____
Due to: _____

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

Major findings: 95C
Of operations: _____
Of autopsy: _____

PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

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. S. Gale (M. D. or other) _____
Address: O. S. Loring, Mo. Date signed: 1/21/48

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

2
0
0

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Vera Gisher....., Registered Apprentice No. *4835*,
working under my personal supervision.

Signed *[Signature]*.....
Licensed Embalmer No. *3960*
P. O. Address *Mayfield 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.