

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

4137

State File No.

Registration District No. 47

Primary Registration District No. 3608

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital No 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-9-47 to 2-3-48
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Will Hanks

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

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife Isabel 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

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

65 to 75 or older

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Will Hanks Sr

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

14. Maiden name Martha Tott

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

16. (a) Informant Sammie Hanks

(b) Address Steele, Mo Route 1

17. (a) Removal (b) Date thereof 2-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steele, Mo

18. (a) Signature of funeral director Thallice Funeral Home

(b) Address 776 1/2 St. Fulton, Missouri

19. (a) Feb 4 48 (b) John Morrison Kluff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway 14

(c) City or town Fulton, Mo 1
(If outside city or town limits, write "RURAL")

(d) Street No. State Hospital 2
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3 year 1948 hour 9 A. M. minute _____ M.

21. I hereby certify that I attended the deceased from Jan. 8, 47 to 2-3-48, 19____, to _____, 19____; that I last saw him alive on Feb. 3, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 0
Duration

Due to _____

Due to _____

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

Major findings: Of operations None 0 3 A

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) NO

(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) (c) Means of injury 0

23. Signature J. B. Caldwell M.D. (M. D. or other) 0

Address M. J. M. Date signed 2-4-48

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

Date Filed 9/13/48
District File Number _____
District Health Officer No. 9,

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 Wenzel P. Browning
Licensed Embalmer No. 2724
P. O. Address Hubton 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.