

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **4241**

FILED FEB 21 1948

Registration District No. **6948**Primary Registration District No. **4107**Registrar's No. **2**

1. PLACE OF DEATH:

- (a) County **CO. D. A. R.**
(b) City or town **EL DORADO SPRINGS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution

(Specify whether

In this community **40 YRS.**
years, months or days)3. (a) PRINT
FULL NAME **JOHN AMOS**

3. (b) If veteran,
-
- name war
-

3. (c) Social Security
-
- No.
-

4. Sex
- MALE**
-
5. Color or
-
- race
- W**

6. (a) Single, widowed, married,
-
- divorced
- SINGLE**

6. (b) Name of husband or wife
-

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

7. Birth date of deceased
- MAR 6 1867**

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

80**10****2**

hr. min.

9. Birthplace
- MO**

(City, town, or county)

(State or foreign country)

10. Usual occupation
- FARMER**

11. Industry or business

12. Name
- UNKNOWN**

13. Birthplace
- UNKNOWN**

(City, town, or county)

(State or foreign country)

14. Maiden name
- UNKNOWN**

15. Birthplace
- UNKNOWN**

(City, town, or county)

(State or foreign country)

16. (a) Informant
- E. F. Amos**

- (b) Address
- 309 S. 2nd**

17. (a)
- BURIAL**

- (b) Date thereof
- 1-11-48**

(Month) (Day) (Year)

- (c) Place: burial or cremation
- Sandridge, Mo.**

18. (a) Signature of funeral director
- Swain Carathus**

- (b) Address
- El Dorado Springs, Mo.**

19. (a)
- 1-10-48**

- (b)
- John Amos**

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **Cedar** 20
(c) City or town **El Dorado Springs, Mo.**
(If outside city or town limits, write "RURAL")

- (d) Street No.
-

(If rural, give location)

- (e) Citizen of foreign country?
-

(Yes or No)

If yes, name country: **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Jan.**
- day
- 8**
-
- year
- 1948**
- hour
- 10**
- minute
- 0**
- P.M.

21. I hereby certify that I attended the deceased from
- Dec 30th**
- , 19
- 48**
- to
- Jan 8**
- , 19
- 48**
- .
-
- that I last saw him alive on
- Jan 8**
- , 19
- 48**
- .
-
- and that death occurred on the date and hour stated above.

Immediate cause of death

Pneumonia

Duration

Due to **---**Due to **---**

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations **---**Of autopsy **---**

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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
- E. F. Amos**

(M. D. or other) **SO.**Address **El Dorado Spgs.**Date signed **1-10-48**

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 1-48-87
Date Filed 2-20-88

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

James E. Hackleman, Registered Apprentice No. 44
working under my personal supervision.

Signed

Floyd B. Carothers

Licensed Embalmer No. 4419

P. O. Address Donado Springs

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistration District No. 61Primary Registration District No. 4107Registrar's No. 2

1. PLACE OF DEATH:

- (a) County Cedar
(b) City or town Elkader Springs
(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)

3. (a) PRINT
FULL NAME

3. (b) If veteran, name war John Ames
3. (c) Social Security No. m m w

4. Sex m 5. Color W 6. (a) Single, widowed, married, divorced

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

7. Birth date of deceased March 6
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 14 (If less than one day, hr. min.)

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

10. Usual occupation

11. Industry or business

12. Name

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

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")

- (d) Street No. (If rural, give location)

- (e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March
year 1948 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 9 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

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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. D. or other)

Address Date signed

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

4241