

No. 2
1-2-43
17339
X38897

FILED APR 21 1948 3

State File No. _____

Registration District No. _____

Primary Registration District No. 3037

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt. Vernon Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Native
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence 55

(c) City or town Mt. Vernon P. R.
(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 _____

3. (a) PRINT FULL NAME Charles B. Foust

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 8- 8- 1872
(Month) (Day) (Year)

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

75	8	0	hr. min.
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9. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name W. M. Foust 9

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

14. Maiden name Mary Harshburger

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

16. (a) Informant Mrs. Mary Misener

(b) Address Mt. Vernon Mo. P. R.

17. (a) Burial (b) Date thereof 4-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hope wells

18. (a) Signature of funeral director Mary Misener

(b) Address ash Grove Mo.

19. (a) 4/15/48 (b) R. Philbrick
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8
year 1948 hour 10 minute 20 A. M.

21. I hereby certify that I attended the deceased from Feb 1st
1948 to April 8 1948
that I last saw him alive on March 24 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarct
had irregular heart in cat
7 volume for past 6 mos. Duration 6 mos

Due to all that complicated
malnutrition in the liver area

Due to _____

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

Major findings: _____
Of operations _____ H&T ADDITIONAL
Of autopsy _____ SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN
I hereby certify that the cause of 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) (a) Means of injury 2

23. Signature Stanley J. Hayward (M.D. or other) D.O.
Address Mt. Vernon Date signed 4-13-48

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

RECEIVED

District Health Officer No. 6;

District File Number 448-450

Date Filed APR 20 1948

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 L. R. Jensen

Licensed Embalmer No. 3297

P. O. Address Miller 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.

Registration District No. 343

Primary Registration District No. 3037

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town McVernon
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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

Charles B. Fournier

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M Color or race W

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

6. (b) Name of husband or wife _____

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

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

8. AGE:

Years 75 Months _____ Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____

(b) _____

(Date received local registrar)

(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 _____ Day _____

Year 1948 hour _____ minute _____ M. 8

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

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 _____

Myocardial Degeneration and failure

Due to Reducing Circulatory Blockage and Gastro-Intestinal Blockage

Due to Cancer of the Liver and adjacent Organs

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 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 Stanley J. Haywood _____ or other _____

Address McVernon, Mo.

Date signed 5/15/48

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

SUPPLEMENTARY

S-13224