

1. PLACE OF DEATH:

(a) County Ballinger
 (b) City or town near Ballinger
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Bonas Nursing Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME OSCAR BROWN JARED
 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 Widowed
 6. (b) Name of husband or wife: Mumie Anna Metzger 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased: Feb 7, 1870
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>78</u> | <u>4</u> | <u>1</u> | hr. min. |

9. Birthplace: Macedo Kentucky
 (City, town, or county) (State or foreign country)

10. Usual occupation: Veterinary

11. Industry or business:

12. Name: Oscar Jared
 13. Birthplace: Kentucky
 (City, town, or county) (State or foreign country)

14. Maiden name:
 15. Birthplace: _____
 (City, town, or county) (State or foreign country)

16. (a) Informant: Oscar Jared
 (b) Address: Advance Mo.

17. (a) Burial (b) Date thereof: June 10, 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Pleasant Hill Cem

18. (a) Signature of funeral director: Walter S. Morgan
 (b) Address: Advance Mo.

19. (a) 7-1-48 (b) Bernard Morgan
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
 (c) City or town: Advance
 (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: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
 year 1948 hour 10 minute 50 A.M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on 6/7/48, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
 Duration: _____

Due to: _____
 Due to: _____

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

Major findings: 830
 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? _____
 (Specify type of place) _____
 While at work? _____ Means of injury: _____

23. Signature: John J. Morgan (M. D. or other) MD
 Address: Advance Mo Date signed: 6/9/48

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

RECEIVED

District Office No. #

District File Number ~~208~~ 7

Date Filed 20 12 - 47

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.....

William H Morgan, Registered Apprentice No. *208*
working under my personal supervision.

Signed

Lloyd S. Morgan

Licensed Embalmer No. *3361*

P. O. Address *Advance, 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.