

FILED JUL 20 1948
Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 181

1. PLACE OF DEATH:

(a) County Rinn
(b) City or town Marcelline
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St Francis
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs
(Specify whether years, months or days) 78 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Rinn 58
(c) City or town M
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME Edward Wilmot Jayler

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

4. Sex male race white 5. Color or white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Jaye Wilmot Jayler 6. (c) Age of husband or wife if 64 years
7. Birth date of deceased March 14 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>3</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Watauga W. Va.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Druggist

11. Industry or business _____

12. Name Edward H. Jayler

13. Birthplace Isle of Wight England
(City, town, or county) (State or foreign country)

14. Maiden name Emma Jane Wilmot

15. Birthplace Oneida Knoxville Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jaye Wilmot Jayler

(b) Address Marcelline Mo

17. (a) Burial (b) Date thereof July 4 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Olivet

18. (a) Signature of funeral director James M. Laughlin
(b) Address Marcelline Mo

19. (a) July 4 1948 (b) Mary Jane Owens
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 2 1948 to July 2 1948
that I last saw him alive on July 52 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis & myocardial infarction

Due to _____

Due to _____

Other conditions (Include pregnancy within 5 months of death) _____

Major findings: Of operations Op

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? _____ (Specify type of place) (Means of injury) _____

23. Signature Rebeccah Smith (M. D. certificate) _____
Address Marcelline Date signed July 4

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Camden, 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Blanche McLaughlin
Licensed Embalmer No. 1909
P. O. Address. Marcelline

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. 585

Primary Registration District No. 8589

1. PLACE OF DEATH:
(a) County Leinn
(b) City or town mauerline
(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) (Specify whether _____)
3. (a) PRINT FULL NAME Edward W. Taylor
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased march (Month) 23 (Day) 1948 (Year)

8. AGE: Years 79 Months 3 Days _____ (Less than one Day) _____ hr. _____ min.

9. Birthplace _____ (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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Mary Jane Adams (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town St. Francis's Hospital - 2 (If outside city or town limits, write "RURAL")
(d) Street No. Marceline, Mo. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July - 1948 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings:
Of operations _____
Of autopsy _____

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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—WRITE IN PREPARATION

880

5-23515