

FILED AUG 23 1948
Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution.....
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

3. (a) PRINT

FULL NAME.....

3. (b) If veteran,

name war.....

3. (c) Social Security No.

name war.....

4. Sex.....
5. Color or race.....
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.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 0 26

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) AUG 14 1948 (b).....
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(d) Street No.....
(e) Citizen of foreign country?.....
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
year..... hour..... minute..... P. M.

21. I hereby certify that I attended the deceased from.....
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?.....
(Specify type of place)

While at work..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

PHYSICIAN

Underline the cause of which death should be charged statistically.

8212 N. Burg
Dened 2-4 PM.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.