

BIRTH NO. _____ REG. DIST. NO. 352 PRIMARY REG. DIST. NO. 4514

030

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Taney</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Taney</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hallister</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hallister MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location) <u>1060</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>J.</u> c. (Last) <u>Wertz</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> - <u>12</u> - <u>50</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 27-1871</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>family</u>	11. BIRTHPLACE (State or foreign country) <u>Hallister MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Miss Huss Wertz</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Tom Wertz</u> ADDRESS <u>Branson</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>(20)</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Don't know</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR

I hereby certify that I attended the deceased from 3-12, 1950, to 3-12, 1950, that I last saw the deceased alive on 3-12, 1950, and that death occurred at A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Larry Kenneth Cozart</u>	23b. ADDRESS <u>Branson MO</u>	23c. DATE SIGNED <u>3-12-50</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE <u>3-15-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hallister Knob</u>	24d. LOCATION (City, town, or county) (State) <u>Hallister MO</u>
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DATE REC'D BY LOCAL REG. <u>Mar 17-1950</u>	REGISTRAR'S SIGNATURE <u>J. E. Copwell</u>	376	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wheeler Funeral Home</u> ADDRESS
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RECEIVED MAR 20 1950

District Health Office No. 6,

District File Number 350-331

Date Filed 3-20-50

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Minnie L. Wheelock

Licensed Embalmer No. 2277

P. O. Address Princeton 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.