

FILED *July 7 1945*

Registration District No. _____

Primary Registration District No. *3023*

Registrar's No. *129*

1. PLACE OF DEATH:

(a) County *Henry*
(b) City or town *Clinton RR #5*
(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 *40 years* years, months or days

3. (a) PRINT FULL NAME *LETA BYSOR*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Married*
6. (b) Name of husband or wife *Joe Bysor* 6. (c) Age of husband or wife if alive *60* years
7. Birth date of deceased *July 15 1884* (Month) (Day) (Year)

8. AGE: Years *60* Months *11* Days *14* If less than one day hr. _____ min. _____

9. Birthplace *Clay Co Mo* (City, town, or county) (State or foreign country)

10. Usual occupation *HOUSE WORK*

11. Industry or business

MOTHER FATHER { 12. Name *James King*
13. Birthplace *Clay Co Mo* (City, town, or county) (State or foreign country)
14. Maiden name *Sarah Daye Brandenburg*
15. Birthplace *Clay Co Mo* (City, town, or county) (State or foreign country)

16. (a) Informant *Joe Bysor*

(b) Address *Clinton RR #5*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *July 1 1945* (Month) (Day) (Year)

(c) Place: burial or cremation *Englewood*

18. (a) Signature of funeral director: *Consensus Peak*

(b) Address *June Clinton Mo*

19. (a) *129* (Date received local registrar) (b) *Myrtle Brourlas* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Henry*
(c) City or town *Clinton Mo RR #5* (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? *1* (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *29* year *1945* Hour *3* minute *30* A. M.

21. I hereby certify that I attended the deceased from *June 6 1945* to *June 29 1945* that I last saw her alive on *June 29 1945* and that death occurred on the date and hour stated above.

Immediate cause of death *Cerebral thrombosis* Duration *11 hrs*
Due to *Cerebral embolus* ?

Due to _____
Other conditions *Chr. myocarditis & fibrillation* ? (Include pregnancy within 3 months of death)

Major findings: Of operations *none* Of autopsy *none* 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) Means of injury _____

23. Signature *S. B. King* (M. D. or _____) Address *Clinton Mo* Date signed *7/24*

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

RECEIVED

District Health Officer No. _____
District File Number 6-45-685-
Date Filed 7-12-45-

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 J. E. Lonsdale

Licensed Embalmer No. 1891

P. O. Address Clinton Ms

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.