

**FRIED JUL 9 1945**

Registration District No. **5183**

Primary Registration District No. **5183**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **CAPE GIRARD**  
(b) City or town **RURAL** (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Byrd**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **83 years** (Specify whether years, months or days)  
In this community **83 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cape Gir**  
(c) City or town **Rural** (If outside city or town limits, write "RURAL")  
(d) Street No. **1 mile East Fruitland** (If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **W. P. MONTON**

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 **MAY MENEELY-MONTON** 6. (c) Age of husband or wife if alive **82** years  
7. Birth date of deceased **October 30 1861** (Month) (Day) (Year)

8. AGE: Years **83** Months **6** Days **11** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **CAPE GIRARD** (City or town or county) **MO** (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

12. Name **H. I. AM-G. MONTON**

13. Birthplace **CAPE GIRARD** (City or town or county) **MO** (State or foreign country)

14. Maiden name **MARCEY-RUFF**

15. Birthplace **CAPE GIRARD** (City or town or county) **MO** (State or foreign country)

16. (a) Informant **Mrs. M. C. Campbell**

(b) Address **Cape Girard Mo**

17. (a) **Burial** (b) Date thereof **6-12-1945** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **pleasant hill Cem**

18. (e) Signature of funeral director **Wilson-Statler-Leaborn**

(b) Address **Jackson Mo**

19. (a) **June 12 1945** (Date received local registrar) **J. H. Fisher** (Registrar's signature)

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month **June** day **11** year **1945** hour **6** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **June 5** 1945 to **June 11** 1945 that I last saw him alive on **June 7** 1945 and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation**  
Due to **arteriosclerosis**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **None**

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? \_\_\_\_\_

(e) Signature **D. L. Leaborn** (Specify type of place) (e) Means of injury **None**

23. Signature **J. H. Fisher** (M. D.) Address **Jackson Mo** Date signed **6-11-45**

Duration **10 days about 8 yrs**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

6  
0  
6

RECEIVED

District Health Officer No. Y  
District File Number 245-824  
Date Filed 7-7-45

**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 Glenn Wilson  
Licensed Embalmer No. 2828  
P. O. Address Jackson 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.**