

1. PLACE OF DEATH:

(a) County Cape Girardian
(b) City or town Shawnee town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Shawnee town
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 84 years years, months or days

3. (a) PRINT FULL NAME AISEY-C-BEAL

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 W
6. (b) Name of husband or wife JAMES-B-BEAL 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 (Month) 26 (Day) 1859 (Year)

8. AGE: Years 84 Months 6 Days 22 If less than one day hr. _____ min. _____

9. Birthplace Cape Gir. (City, town, or county) MO (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name James Whitledge

13. Birthplace Cape Gir. (City, town, or county) MO (State or foreign country)

14. Maiden name Wilson Nations

15. Birthplace Cape Gir. (City, town, or county) MO (State or foreign country)

16. (a) Informant Mrs. F.E. Bonney

(b) Address Shawnee town

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge Mem.

18. (a) Signature of funeral director Wilson Staller Sealbaugh

(b) Address Jackson MO

19. (a) 5-20-44 (Date received local registrar) (b) Henry Stout (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir.
(c) City or town Shawnee town (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 18
year 1944 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from D-C 1943 to 5-18 1944
that I last saw her alive on May 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiomyopathy of the heart

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 53

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) (e) Means of injury _____

23. Signature P.D. Graylock (M. D. or other) M.D.
Address Oak Ridge MO Date signed 5-18-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

7823

1328

RECEIVED

District Health Officer No. 4

District File Number 644-3893

Date Filed 6-6-44

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.