

FILED MAR 26 1948

Registration District No. 212

Primary Registration District No. 5180

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Clear Rural Saline
(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 years, months or days)

3. (a) PRINT FULL NAME OLLIE L. AMOS.

3. (b) If veteran, name war. 3. (c) Social Security No. 2

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife 6. (c) Age of husband or wife if

7. Birth date of deceased Mar 29-1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 11 18 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Jamie Lewis

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

14. Maiden name Sarah E. Campbell

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

16. (a) Informant Mrs. M. B. Taylor

(b) Address Clear MO.

17. (a) Rural (b) Date thereof Mar 19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Campbell Cem.

18. (a) Signature of funeral director W. H. Taylor

(b) Address Russellville MO.

19. (a) Mar. 18, 1948 (b) Waverly A. Walt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miller
(c) City or town Clear
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 17
year 1948 hour 7 minute 5 A.M.

21. I hereby certify that I attended the deceased from Feb 7, 1948
to Mar 17, 1948

that I last saw him alive on Feb. 27, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral hemorrhage

Due to Chronic nephritis also

Due to Arthritis deformans

Other conditions. ✓

(Include pregnancy within 3 months of death)

Major findings: ✓

Of operations ✓

Of autopsy ✓

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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. H. Shirley, M.D. (M. D. or other)

Address Engine No. Date signed 3/18/48

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed MAR 25 1948

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. 2307

P. O. Address Russell Hill

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.