

No. 2  
-1/47  
5-17-39

FILED OCT 11 1948

Registration District No. **48**

Primary Registration District No. **4510**

1. PLACE OF DEATH **Sullivan**

(a) County **Sullivan**

(b) City or town **Osgood**  
(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 **Life** years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Sullivan**

(c) City or town **Osgood**  
(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 **-**

3. (a) PRINT FULL NAME **ALTA MYRA WESTON**

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 **wid**

6. (b) Name of husband or wife **-** 6. (c) Age of husband or wife if alive **-** years

7. Birth date of deceased **Mar 30 1866**  
(Month) (Day) (Year)

8. AGE: Years **82** Months **5** Days **23** If less than one day **0** hr. min.

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

10. Usual occupation **House wife**

11. Industry or business **-**

12. Name **A. H. Johnson**

13. Birthplace **Penn** (City, town, or county) (State or foreign country)

14. Maiden name **Martha Maloney**

15. Birthplace **Penn** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Carl Todd**

(b) Address **Seneca Mo**

17. (a) **Burial** (b) Date thereof **9-24-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Campground Cem.**

18. (a) Signature of funeral director **Ph Bayne**

(b) Address **Galt Mo**

19. (a) **Sept 28-48** (b) **Brita Caldwell**  
(Date received local registrar's) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **22** year **1948** hour **-** minute **-** M.

21. I hereby certify that I attended the deceased from **1-1-48**, 19**48**, to **9-22-48**, 19**48**; that I last saw **her** alive on **9-22-1948**; and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma Liver** Duration **?**

Due to **-**

Due to **-**

Other conditions: **-**  
(Include pregnancy within 3 months of death)

Major findings: **H&K**  
Of operations **-**

Of autopsy **-**

PHYSICIAN  
Underline the cause of 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 **U.C. Weston** (M.D. or other)

Address **Galt Mo** Date signed **9-23-48**

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 10  
District File Number 10-48-120  
Date Filed OCT 2 - 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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spikard 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.