

S. No. 2
OM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER
FILED JAN 3 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39959

Registration District No. 141

Primary Registration District No. 557 30 25

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 21 1/2 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46

(c) City or town West Plains Mo 1
(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 _____

3. (a) PRINT FULL NAME John D. Cargill

3. (b) If veteran, name war No

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Dec 4 1948 to Dec 10 1948
that I last saw him alive on Dec 4 1948
and that death occurred on the date and hour stated above.

4. Sex MO

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife FANNIE CAYOILL

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: April 4 1873
(Month) (Day) (Year)

Immediate cause of death Senile Dementia

Due to Arteriosclerosis
Myocarditis

Due to _____

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

8. AGE: Years Months Days If less than one day

75 8 6 - hr. - min.

9. Birthplace May Field Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name SAMUEL CAYOILL

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

14. Maiden name MARY Fowler

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

Major findings: Of operations _____

Of autopsy 93P

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant FANNIE CAYOILL

(b) Address RT #3 West Plains Mo

17. (a) B (b) Date thereof 12-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fowler Cemetery

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? _____

18. (a) Signature of funeral director Robertus

(b) Address West Plains Mo

19. (a) Dec 21-48 (b) Beatrice Cook
(Date received local registrar) (Registrar's signature) 379

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Joseph D. Smith (M. D. or nurse) YD

Address West Plains Mo Date signed 12/10/48

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 12-27-48
District Health Officer No. 5,
District File Number 1248899
Date Filed 12-27-48

65001 2 8 80A

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 George R. Dray

Licensed Embalmer No. 4480

P. O. Address West Plains, 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.