

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. 42409

FILED JAN 31 1949

S. No. 300
V. 10.48

BIRTH NO. _____		REG. DIST. NO. <u>71</u>	PRIMARY REG. DIST. NO. <u>3012</u>	Registrar's No. <u>178</u>
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>		c. LENGTH OF STAY (in this place) <u>3 YEARS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>251 1/2 EAST BROADWAY</u>		d. STREET ADDRESS (If rural, give location)* <u>251 1/2 EAST BROADWAY</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>SAMSON</u> c. (Last) <u>POPE JOY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 31, 1948</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 27, 1893</u>	9. AGE (In years last birthday) <u>55</u> IF UNDER 1 YEAR: Months <u>10</u> Days <u>4</u> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLLTON, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOHN POPE JOY</u>		
13b. MOTHER'S MAIDEN NAME <u>LITTISHA McCASKEY</u>		14. NAME OF HUSBAND OR WIFE <u>NELLIE VANMETER POPE JOY</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES, WORLD WARR. 1918</u>		16. SOCIAL SECURITY NO. <u>513-14-08371</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Nellie Popejoy</u> ADDRESS <u>Excelsior Springs, Mo.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>4 MONTHS</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs. 1/2 hr.</u>		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary arterial sclerosis & coronary atherosclerosis + ventricular fibrillation</u>		*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		
ANTECEDENT CAUSES		DUE TO (b) _____		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4500 97		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Excelsior Springs Clay Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>2-10</u> , 19 <u>48</u> , to <u>12-31</u> , 19 <u>48</u> , that I last saw the deceased alive on <u>12-31</u> , 19 <u>48</u> , and that death occurred at <u>1:30 P</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Paul W. Morgan, M.D.</u>		23b. ADDRESS <u>Excelsior Springs Mo.</u>		23c. DATE SIGNED <u>1-3-48</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JAN. 3, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>
24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Claude Prichard</u>		
DATE REC'D BY LOCAL REG. <u>1/8/49</u>		REGISTRAR'S SIGNATURE <u>Margaret Hutchinson</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 1-29-49

JAN 31 1949

RECEIVED

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Robert E. White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs

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.