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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 2 1949

7282

State File No.

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 5014 Registrar's No. 323

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Jefferson</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Jefferson Township</u>	
c. LENGTH OF STAY (In this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>4 miles N.E. of St. Joseph, Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 miles N.E. St. Joseph</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Celina</u>	b. (Middle) <u>E.</u>	c. (Last) <u>Verdier</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 18, 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 7, 1874</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Martin Hughes</u>	13b. MOTHER'S MAIDEN NAME <u>Matilda Connett</u>	14. NAME OF HUSBAND OR WIFE <u>J. M. Verdier</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If you give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>W. C. Verdier, R.R. #3,</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>640</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cosinophilic Leukemia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <u>Secondary anemia</u>		540	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5 MARCH, 1949, to 16 MARCH, 1949, that I last saw the deceased alive on 17 MARCH, 1949, and that death occurred at 3:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William Spark</u>	23b. ADDRESS <u>St. Joseph, Mo</u>	23c. DATE SIGNED <u>3-19-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/21/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Andrew County, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>3/26/49</u>	REGISTRAR'S SIGNATURE <u>William Spark</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Verdier</u>	ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed William Spalding

Signed _____
Student Embalmer

Licensed Embalmer No. 4585

P. O. Address 319 S. 11th St. Fargo, N.D.

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.