

No. 300  
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49

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8913

FILED APR 4 1949

State File No. ....

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

|   |                               |   |  |  |   |   |                                  |
|---|-------------------------------|---|--|--|---|---|----------------------------------|
| BIRTH NO. _____   |                               | REG. DIST. NO. <u>157</u>   |  | PRIMARY REG. DIST. NO. <u>5584</u>   |   | Registrar's No. <u>63</u>   |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jasper</u>  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> |   |   |                                  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>rural -- McDonald</u>   |                               |   | c. LENGTH OF STAY (In this place) <u>75 yrs</u>            | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>rural -- McDonald</u>                                      |   |   | 0                                |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rte 2, Sarcoxie</u>  |                               |   |  | d. STREET ADDRESS (If rural, give location) <u>Rte 2, Sarcoxie</u>   |   |   |                                  |
| 3. NAME OF DECEASED (Type or Print)   |                               | a. (First) <u>WALKER</u>  |  | b. (Middle) <u>AZEL</u>  |   | c. (Last) <u>WHITE</u>  |                                  |
|   |                               |   |  |  |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 22, 1949</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>Oct. 7, 1863</u>                       |  | 9. AGE (In years last birthday) <u>85</u>                                     | IF UNDER 1 YEAR Months  | IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Linn, Missouri</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                               |                                  |
| 13a. FATHER'S NAME <u>James White</u>   |                               |   | 13b. MOTHER'S MAIDEN NAME <u>unknown</u>                   |  |   | 14. NAME OF HUSBAND OR WIFE <u>Juanita M. White</u>                   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                               | 16. SOCIAL SECURITY NO. <u>none</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. W. A. White, Rte 2, Sarcoxie, Mo</u>   |   |   |                                  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  |                               | MEDICAL CERTIFICATION   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| <p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>   |                               | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Nephritis with infection</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) <u>593X</u>  |  |  |   |   |                                  |
|   |                               | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dissection on leg</u> |  |  |   |   |                                  |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION <u>✓</u>   |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 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)  |   |   |                                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.  |                               | 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>Mar 1, 1949</u> , to <u>Mar 22, 1949</u> , that I last saw the deceased alive on <u>Mar 21, 1949</u> , and that death occurred at <u>11:45 A.</u> , from the causes and on the date stated above. |                               |   |  |  |   |   |                                  |
| 23a. SIGNATURE (Degree or title) <u>L. J. Holmes M.D.</u>   |                               |   |  | 23b. ADDRESS <u>Miller Mo.</u>   |   | 23c. DATE SIGNED <u>3/24/49</u>                                       |                                  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>   |                               | 24b. DATE <u>Mar 25, 1949</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Faskins Cemetery</u> |  | 24d. LOCATION (City, town, or county) (State) <u>Jasper County, Missouri.</u> |   |                                  |
| DATE REC'D BY LOCAL REG. <u>Mar 25 1949</u>   |                               | REGISTRAR'S SIGNATURE <u>L. B. Clinton M.D.</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Knell Mortuary</u>   |   | ADDRESS <u>Carthage, Mo.</u>  |                                  |

Per. H. Ferguson (Licensed Embalmer's Statement on Reverse Side)

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 Frank W. Keele.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 4440.....

P. O. Address Carthage.....

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.