

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

State File No. 11400

No. 300
10.48

FILED APR 23 1949

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 5001 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY <u>Adair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Greentop "Rural"</u>		c. LENGTH OF STAY (in this place) <u>Life</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Greentop</u>		d. STREET ADDRESS (If rural, give location) <u>Rural Route</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>East of Greentop</u>					

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mollie</u> b. (Middle) _____ c. (Last) <u>Mikel</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 12 1949</u>		
--	--	--	---	--	--

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>Nov. 7, 1877</u>	9. AGE (in years last birthday) <u>71</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>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Adair County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	---	--	--

13a. FATHER'S NAME <u>William Conner</u>		13b. MOTHER'S MAIDEN NAME <u>Emmaline Crow</u>		14. NAME OF HUSBAND OR WIFE <u>Warren C. Mikel</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>Cecil Conner, Greentop, Mo</u>			
---	-------------------------------------	--	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertension & Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>443X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
--	--	--	--	---

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) _____	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 3-28, 1949, to 4-11, 1949, that I last saw the deceased alive on 4-11, 1949, and that death occurred at 4:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>[Signature]</u>		23b. ADDRESS <u>[Address]</u>	23c. DATE SIGNED <u>4-14-49</u>
---	--	-------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/14/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ft. Madison</u>	24d. LOCATION (City, town, or county) (State) <u>Adair County, Mo</u>
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>4-20-49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature], Kirksville, Mo.</u>	
---	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

APR 28 1949

RECEIVED

District Health Officer No. 1

District File Number 44970

Date Filed APR 22 1949

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 Roy H. Mercer

Signed.....
Student Embalmer

Licensed Embalmer No. 4432

P. O. Address Kirkville, 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.