

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15055

State File No.

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 197

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).		
a. COUNTY <u>Callaway</u>			a. STATE <u>Mo</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>		c. LENGTH OF STAY (in this place) <u>257 37m</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Paris</u>		b. COUNTY <u>monroe</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp #1</u>			d. STREET ADDRESS (If rural, give location) <u>2</u>		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>ED</u>	b. (Middle)	c. (Last) <u>DYE</u>	Month <u>May</u>	Day <u>28</u>	Year <u>1949</u>
5. SEX <u>on W</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>Aug 24-1885</u>	9. AGE (In years last birthday) <u>63</u>	10. IF UNDER 1 Yr. Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>dk</u>	11. BIRTHPLACE (State or foreign country) <u>mo O</u>		12. CITIZEN OF WHAT COUNTRY? <u>us</u>	

13a. FATHER'S NAME <u>Rame Dye</u>	13b. MOTHER'S MAIDEN NAME <u>Hollis</u>	14. NAME OF HUSBAND OR WIFE <u>dk</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>dk</u>	16. SOCIAL SECURITY NO. <u>dk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. E.M. Cunningham</u>	ADDRESS <u>605 W 112</u>
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18. CAUSE OF DEATH	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ch interstitial myocarditis</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		
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) <u>Syphilis</u>		
	DUE TO (c) <u>Cardiac hypertrophy</u>		<u>5977X</u>
	II. OTHER SIGNIFICANT CONDITIONS:		
	Conditions contributing to the death but not related to the disease or condition causing death. <u>pul. edema</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accidental suicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hosp #1</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Fulton Callaway Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>5-28-49 3:30m</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Cut R. wrist with knife</u>

22. I hereby certify that I attended the deceased from 5/28, 1949, to 5/28, 1949, that I last saw the deceased alive on 5/28, 1949 and that death occurred at 5:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J Caldwell MD</u>	23b. ADDRESS <u>State Hosp Fulton Mo</u>	23c. DATE SIGNED <u>5/28/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 2, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp. Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Fulton, Mo</u>
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DATE REC'D BY LOCAL REG <u>June-1-1949</u>	REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Champ Weeks</u>	ADDRESS <u>Fulton, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed JUN 8 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.

Student

Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.