

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16400**

BIRTH NO. _____		REG. DIST. NO. <u>164</u>		PRIMARY REG. DIST. NO. <u>3022</u>		Registrar's No. <u>5960</u>	
1. PLACE OF DEATH a. COUNTY <u>JOHNSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JOHNSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WARRENSBURG</u>		c. LENGTH OF STAY (In this place) <u>2 WEEKS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL KINGSVILLE</u>		d. STREET ADDRESS (If rural, give location) <u>ROUTE # 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>WARRENSBURG CLINIC</u>				d. STREET ADDRESS (If rural, give location) <u>ROUTE # 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>URIAS</u> b. (Middle) <u>WINFREY</u> c. (Last) <u>CARLYLE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 9 1949</u>				
5. SEX <u>M O W</u>		6. COLOR OR RACE <u>MARRIED</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>NOV 7 1870</u>	
9. AGE (In years last birthday) <u>78</u>		10. MONTHS <u>6</u>		11. DAYS <u>2</u>		12. HOURS <u>0</u> MIN. <u>0</u>	
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>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>KINGSVILLE MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>W W CARLYLE</u>		13b. MOTHER'S MAIDEN NAME <u>RUTH WILLIAMS</u>		14. NAME OF HUSBAND OR WIFE <u>MARY FRANCES CARLYLE</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 <u>Hester Carlyle</u> ADDRESS <u>Mo</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Lymphatic Leukemia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2</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 Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>					<u>2040</u>
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Warrensburg Johnson Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>May 1 - 1949</u> , to <u>May 9, 1949</u> , that I last saw the deceased alive on <u>5-9-49</u> , and that death occurred at <u>7:45 PM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R T Max</u>				23b. ADDRESS <u>Mo</u>		23c. DATE SIGNED <u>5-13-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAY 13 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ELM SPRINGS</u>		24d. LOCATION (City, town, or county) (State) <u>ELM MO</u>	
DATE REC'D BY LOCAL REG. <u>May 13, 1949</u>		REGISTRAR'S SIGNATURE <u>Savannah</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Canada</u>		ADDRESS <u>Holden, Mo</u>	

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

51  
2  
2

MAY 17 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. 279

working under my personal supervision.

Student Robert L. Stewart, Jr.

Student Embalmer

Signed \_\_\_\_\_

M. R. Canada

Licensed Embalmer No. 3434

P. O. Address Halden, 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.