

FILED JUL 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20492**

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 216

1. PLACE OF DEATH a. COUNTY PETTIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY PETTIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SEDALIA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SEDALIA	
d. FULL NAME OF HOSPITAL OR INSTITUTION BOTHWELL MEMORIAL HOSPITAL		d. STREET ADDRESS (If rural, give location) 27th & Massachusetts	
3. NAME OF DECEASED (Type or Print) a. (First) CHRISTOPHER b. (Middle) COLUMBUS c. (Last) PAXTON			4. DATE OF DEATH July 1 1949
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 17 1861
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) 88
11. BIRTHPLACE (State or foreign country) Cooper Co., Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Sam Paxton		13b. MOTHER'S MAIDEN NAME Maggie (last name unkn.)	14. NAME OF HUSBAND OR WIFE O.E. Beeler, Sedalia, Mo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME O.E. Beeler, Sedalia, Mo ADDRESS _____
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Enlargement of Prostate gland ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		197X	
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>June 25, 1949</u> , to <u>July 1, 1949</u> , that I last saw the deceased alive on <u>July 30, 1949</u> , and that death occurred at <u>7 a m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE Ed Scovrey, M.D. (Degree or title)		23b. ADDRESS Sedalia Mo	23c. DATE SIGNED July 1 49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2 July 1949	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) Sedalia, Mo
DATE REC'D BY LOCAL REG. 7-1-49	REGISTRAR'S SIGNATURE Betty Yeager	25. FUNERAL DIRECTOR'S SIGNATURE W. Heckart ADDRESS Sedalia, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

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JUL 5

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 7-13-49

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 Frank S Coffman Jr.

Licensed Embalmer No. 45569

P. O. Address Sedalia, 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.