

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22428**

FILED AUG 5 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>224</u>	
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>Kirkville</u>		c. LENGTH OF STAY (in this place) <u>50 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Anna R. Still Con. Home</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Laura</u>			b. (Middle) <u>Isabelle</u>		c. (Last) <u>Millay</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>23</u> (Year) <u>49</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>10-7-53</u>		9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Sterling, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Hiram Gardner</u>			13b. MOTHER'S MAIDEN NAME <u>Emily Phillips</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER 'IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Edna Campbell-Kirkville, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Medullary Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Thrombotic encephalomalacia</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 year</u> <u>years</u> <u>4500</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____		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>Jan 22, 1948</u> , to <u>July 23, 1949</u> , that I last saw the deceased alive on <u>July 23, 1949</u> , and that death occurred at <u>1:45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. T. Gutschahn D.O.</u>				23b. ADDRESS <u>Kirkville, Mo</u>		23c. DATE SIGNED <u>7-23-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-25-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fernest Park</u>		24d. LOCATION (City, town, or county) (State) <u>Kirkville, Mo</u>		
DATE REC'D BY LOCAL REG. <u>7-27-49</u>		REGISTRAR'S SIGNATURE <u>Hate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Our Funeral Home, Kirkville, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED AUG 2 1949
District Health Officer No.
District File Number 8-49-13
Date Filed AUG 2 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 _____

Clarence M. Bill

Signed _____

Student Embalmer

Licensed Embalmer No. 4375

P. O. Address Rickville, Me

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.