

FILED OCT 25 1949

STANDARD CERTIFICATE OF DEATH

State File No. 32941

BIRTH NO. _____ REG. DIST. NO. 20 PRIMARY REG. DIST. NO. 4031 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission). a. STATE Missouri b. COUNTY Bates	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Adrian)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Adrian	
c. LENGTH OF STAY (in this place) 40 yrs		d. STREET ADDRESS (If rural, give location) g	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Frances	b. (Middle) Howard	c. (Last) Deffenbaugh	(Month) Oct.	(Day) 12	(Year) 49
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1871 February 4,	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Johnson Co. Missouri
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Samuel Howard		13b. MOTHER'S MAIDEN NAME Margaret Porter		14. NAME OF HUSBAND OR WIFE Ad Deffenbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Glessner Ray, Adrian Missouri	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) General Arteriosclerosis			
		DUE TO (c) Atherosclerosis + chr.			
II. OTHER SIGNIFICANT CONDITIONS		Nephritis		4221	
Conditions contributing to the death but not related to the disease or condition causing death.					

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 **Jan 2**, 19**47**, to **Oct. 12**, 19**49**, that I last saw the deceased alive on **Oct. 11**, 19**49**, and that death occurred at **8: P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles W. Linter MS		23b. ADDRESS Buteau MO		23c. DATE SIGNED 10/14/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-14-49		24c. NAME OF CEMETERY OR CREMATORY Altona Cemetery	
				24d. LOCATION (City, town, or county) (State) Altona Mo.	

DATE REC'D BY LOCAL REG. 10-14-49		REGISTRAR'S SIGNATURE Myra Owens		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leath & Sif Adrian Mo	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No:
District File Number 9.49.1
Date Filed 7.2.28

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 myself

Fred J. Leath #3343

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3650

P. O. Address Adrian 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.