

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34372**

BIRTH NO. _____		REG. DIST. NO. <u>201</u>		PRIMARY REG. DIST. NO. <u>4315</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>La Plata</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>La Plata</u>		6 1/2	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Morton</u> c. (Last) <u>Self</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 17 1949</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>1-9-1880</u>	
9. AGE (In years last birthday) <u>69</u>		10. MONTHS <u>9</u>		11. DAYS <u>8</u>		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Glasgow, Ky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>James Monroe Self</u>			13b. FATHER'S MAIDEN NAME <u>Sarah Owens</u>		14. NAME OF HUSBAND OR WIFE <u>Anna May Self</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>570-01-0421</u>		17. INFORMANT'S SIGNATURE OR NAME <u>K. B. Self, R.C. 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertensive and arterio-</u> DUE TO (c) <u>sclerotic Heart Disease</u>					
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>4201</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 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>May 17</u> , 19 <u>49</u> , to <u>October 12</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>October 15</u> , 19 <u>49</u> , and that death occurred at <u>7 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. Robert Kuapp M.D.</u>				23b. ADDRESS <u>La Plata, Mo.</u>		23c. DATE SIGNED <u>October 18/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10-20-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>La Plata</u>		24d. LOCATION (City, town, or county) (State) <u>La Plata Mo</u>	
DATE REC'D BY LOCAL REG. <u>Oct 19 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs O L Griffin</u>		186		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Dr. Christie La Plata Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 10/25/49
Macon County Health Department
County File No. 10/49/26
Date Filed 10/25/49

OCT 28 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 D. S. Christie

Licensed Embalmer No. 1109

P. O. Address La Plata Md.

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.