

FILED DEC 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41656**

59 BIRTH NO. _____ REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **5699** Registrar's No. **172**

1. PLACE OF DEATH a. COUNTY Livingston,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE Missouri b. COUNTY Livingston	
b. CITY OR TOWN Avalon, RFD#		c. CITY OR TOWN Avalon,	
c. LENGTH OF STAY (in this place) 60 years		d. STREET ADDRESS RFD # 2 Mill west -	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 2 m. West Avalon.		3. NAME OF DECEASED a. (First) Bettie b. (Middle) Louis c. (Last) Drake,	
4. DATE OF DEATH Nov. 19 1949		5. SEX F	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Nov. 5, 1870		9. AGE (In years last birthday) 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) Frankford, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm. R. Stuart,		13b. MOTHER'S MAIDEN NAME Susan Scott,	
14. NAME OF HUSBAND OR WIFE Chas. W. Drake		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Chas W. Drake, ADDRESS Avalon, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Due to (b) Arteriosclerosis 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. 4731	
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 11, 1947 to Nov 19, 1949 , that I last saw the deceased alive on Nov 10, 1949 , and that death occurred at 4:30 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE C. Callen, M.D. (Degree or title)		23b. ADDRESS Chillicothe Mo	
23c. DATE SIGNED Nov 21 1949		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 11/22/1949		24c. NAME OF CEMETERY OR CREMATORY Avalon	
24d. LOCATION (City, town, or county) (State) Avalon Missouri.		25. FEDERAL DIRECTOR'S SIGNATURE Clifford W. Austin ADDRESS _____	
DATE REC'D BY LOCAL REG. Nov-22-49		REGISTRAR'S SIGNATURE Frances B Neill	

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

on Callen



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.....

Clifford W. Austin

Licensed Embalmer No. **3233**

P. O. Address..... *Tina, Missouri*

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.