

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3735

State File No. _____

0013
0

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>45</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>MACON</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>KIRKSVILLE</u>		c. LENGTH OF STAY (In this place) <u>2 WKS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>LAPLATA - MO</u>		<u>0610</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LAUGHAN HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>BYRON</u>			b. (Middle) <u>FRANKLIN</u>		c. (Last) <u>WORKMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 21, 1950</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>JULY 31, 1860</u>		9. AGE (In years last birthday) <u>89</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. FARMING</u>			11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>MO</u>	
13a. FATHER'S NAME <u>FRIEND WORKMAN</u>			13b. MOTHER'S MAIDEN NAME <u>AMANDA GREGG</u>			14. NAME OF HUSBAND OR WIFE <u>SABINA ELMORE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>KEOLAH KASLEY BRASHEAR 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral Hypostatic Pneumonia (Lobar)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <u>Arteriosclerotic Gangrene of 4th toe of right foot.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>490X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>of right foot</u>						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) _____		21d. (COUNTY) _____		21e. (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>Feb 8, 1950</u> , to <u>Feb 21, 1950</u> , that I last saw the deceased alive on <u>Feb 21, 1950</u> , and that death occurred at <u>8:30 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>W. T. Rhoads, D.O.</u>				23b. ADDRESS <u>Kirkville, Mo.</u>				23c. DATE SIGNED <u>2-23-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>2/24, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MAPLE HILLS</u>		24d. LOCATION (City, town, or county) (State) <u>KIRKSVILLE MO</u>			
DATE REC'D BY LOCAL REG. <u>2-23-50</u>		REGISTRAR'S SIGNATURE <u>Walter Lambert</u>			25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Lambert, D. Hurdless, Mo</u>				

FEB 20 1953

FEB 7 1950

RECEIVED FEB 27 1950
District Health Officer No. 10
Receipt Number 2-58-34
Date Filed FEB 27 1950

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 Bob Casley

Licensed Embalmer No. 3755

P. O. Address Turdous 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.