

STANDARD CERTIFICATE OF DEATH

19228

State File No.

FILED JUN 16 1950

BIRTH NO.		REG. DIST. NO. 1		PRIMARY REG. DIST. NO. 3000		Registrar's No. 145	
1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Adair			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Kirksville)		c. LENGTH OF STAY (In this place) 7 1/2 hours		c. CITY (If outside corporate limits, write RURAL and give township) Rural Liberty		0010	
d. FULL NAME OF HOSPITAL OR INSTITUTION Laughlin Hospital				d. STREET ADDRESS (If rural, give location) Novinger RFD			
3. NAME OF DECEASED (Type or Print) a. (First) Bessie b. (Middle) Summers c. (Last) Durall			4. DATE OF DEATH (Month) (Day) (Year) June 3 1950				
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 21, 1887	
9. AGE (In years; last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY housekeeper		11. BIRTHPLACE (State or foreign country) Macon Co. Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Samuel R. St. Clair		13b. MOTHER'S MAIDEN NAME Isabelle Richardson		14. NAME OF HUSBAND OR WIFE Bert H. Durall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Bert H. Durall ADDRESS Novinger RFD Mo.			
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) Arricular Fibrillation		ANTECEDENT CAUSES				?	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____				_____	
		DUE TO (c) _____				_____	
II. OTHER SIGNIFICANT CONDITIONS Virus Pneumonia		Conditions contributing to the death but not related to the disease or condition causing death.				2 Weeks	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4331			
22. I hereby certify that I attended the deceased from June 3, 1950 , to June 3, 1950 , that I last saw the deceased alive on June 3, 1950 , and that death occurred at 10:10 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE A. T. Rhoads D.O. (Degree or title)				23b. ADDRESS Kirksville, Mo		23c. DATE SIGNED 6-3-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE June 5, 1950		24c. NAME OF CEMETERY OR CREMATORY HIGHLAND PARK		24d. LOCATION (City, town, or county) (State) MIRKSVILLE MO	
DATE REC'D BY LOCAL REG. 6-4-50		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE Leot Beasley, Jr. ADDRESS Hurdland Mo			

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

1961 JUN 7 11 AM

RECEIVED JUN 12 1950
District Health Officer No. 10
District File Number 6-50-972
Date Filed JUN 15 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.

Signed Ter B. Casley Jr

Signed _____
Student Embalmer

Licensed Embalmer No. 3755

P. O. Address Terlaud 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.