

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5637**

FILED MAR 11 1952

BIRTH NO. _____ REG. DIST. NO. **179** PRIMARY REG. DIST. NO. **5669** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lincoln	
b. CITY OR TOWN Hawkpoint		c. CITY OR TOWN Hawkpoint	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED
 a. (First) **WILLIAM** b. (Middle) **THOMAS** c. (Last) **EARNEST**
 (Type or Print) DATE OF DEATH **March 1, 1952**
 (Month) (Day) (Year)

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Divorced** 8. DATE OF BIRTH **Mar 22, 1885** 9. AGE (In years last birthday) **66** Months **11** Days **9** IF UNDER 12 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **laborer for R.E.A.** 10b. KIND OF BUSINESS OR INDUSTRY **Electrical line work** 11. BIRTHPLACE (State or foreign country) **Missouri** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Sam Earnest** 13b. MOTHER'S MAIDEN NAME **Ella Finnes** 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **495-16-2903** 17. INFORMANT'S SIGNATURE OR NAME **Eva Earnest** ADDRESS **Hawkpoint Mo**

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		INTERVAL BETWEEN ONSET AND DEATH 14 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION **331X** 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 2, 1952** to **Mar 1, 1952**, that I last saw the deceased alive on **March 1, 1952** and that death occurred at **1:00 A.M.**, from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) **Dr. H. L. Kelley** 23b. ADDRESS **Troy Mo.** 23c. DATE SIGNED **3-6-52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **Mar 3 52** 24c. NAME OF CEMETERY OR CREMATORY **Hawkpoint Cem.** 24d. LOCATION (City, town, or county) (State) **Hawkpoint Mo**

DATE REC'D BY LOCAL REG. **3-11-52** REGISTRAR'S SIGNATURE **Emma B. Riddle** 162 25. FUNERAL DIRECTOR'S SIGNATURE **Wayne Mc Coy** ADDRESS **Troy Mo**

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

b. 300
0.48
10
1

2
40

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

Wayne Mc Coy

Licensed Embalmer No.

3586

P. O. Address

Troy 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.