

FILED MAR 17 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7205

BIRTH NO.		REG. DIST. NO. 1	PRIMARY REG. DIST. NO. 5008	Registrar's No. 99
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 township) OR TOWN Rural--Walnut Twp.		c. LENGTH OF STAY (in this place) 38 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural--Walnut Twp. 0010 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 10 mi. S. Green Castle		d. STREET ADDRESS (If rural, give location) 10 mi. South Green Castle		
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) McClelland	c. (Last) Page	4. DATE OF DEATH (Month) (Day) (Year) Mar. 9, 1952
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 14, 1861	9. AGE (In years last birthday) 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Page		13b. MOTHER'S MAIDEN NAME Caroline Hensley	14. NAME OF HUSBAND OR WIFE Amanda Page	
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. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Charles Hampton Browning, Mo. ADDRESS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Chronic Bronchitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Age and weakness DUE TO (c) 5021 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
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) (Min)		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 1952, to Mch 9 1952, that I last saw the deceased alive on _____, 19____, and that death occurred at 1 P. m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) W. Huntington MD		23b. ADDRESS Green City. Mo		23c. DATE SIGNED 3-10-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 12 1952	24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State) Sullivan County, Mo	
DATE REC'D BY LOCAL REG. 3-12-52	REGISTRAR'S SIGNATURE Kate Lambert 6	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glenn E. Kent & Son, Green City, Mo.		

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

2010
/

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.