

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **151**

No. 300
19-48

FILED JAN 28 1953

BIRTH NO. _____ REG. DIST. NO. **27** PRIMARY REG. DIST. NO. **3005** Registrar's No. **57**

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

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Bates | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Bates | |
| b. CITY (If outside corporate limits, write RURAL and give township) Butler | | c. CITY (If outside corporate limits, write RURAL and give township) Rural Mt. Pleasant | |
| c. LENGTH OF STAY (in this place) 2 days | | d. STREET ADDRESS (If rural, give location) P. F. D. 0070 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Butler Memorial Hosp. | | | |

| | | | | | |
|--|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) S. c. (Last) Douglass | | | 4. DATE OF DEATH (Month) (Day) (Year) 1-18-53 | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | |
| 8. DATE OF BIRTH 10-18-1863 | | 9. AGE (In years last birthday) 89 | | if UNDER 1 YEAR Months 3 Days _____ Hours _____ Mins. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (City and State or Foreign Country) Windsor, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| 13a. FATHER'S NAME David Douglass | | 13b. MOTHER'S MAIDEN NAME Sarah Woodard | | 14. NAME OF HUSBAND OR WIFE Maggie Douglass | |
| 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 ADDRESS Cora O'Rear Butler, 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) hypo-static pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) fractured L. femur | | | 48 hrs |
| | | DUE TO (c) fall | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E9030 | | | |

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 007 | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Butler, Bates, Mo. | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan. 16 1953 6am | | 21e. INJURY OCCURRED WHILE AT WORK? <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? slipped on icy step | |

22. I hereby certify that I attended the deceased from **1940**, to **Jan. 18**, 1953, that I last saw the deceased alive on **Jan. 18**, 1953, and that death occurred at **9:30 P.M.**, from the causes and on the date stated above.

| | | | | | |
|---|--|---|---------------------------------|--|--|
| 22a. SIGNATURE L. S. LaFue, M.D. (Degree or title) | | | 23b. ADDRESS Butler, Mo. | | |
| 23c. DATE SIGNED 1-22-53 | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Rural | | 24b. DATE 1-21-53 | | 24c. NAME OF CEMETERY OR CREMATORY Cokell Cemetery | |
| | | | | 24d. LOCATION (City, town, or county) (State) Butler, Mo. | |
| DATE REC'D BY LOCAL REG. Jan. 22-53 | | REGISTRAR'S SIGNATURE Randall Kerney | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin Underwood Butler, Mo. | |

(Licensed Embalmer's Statement on Reverse Side)

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

Robert G. Stumberg

Licensed Embalmer No. *4657*

P. O. Address *Butte, Md.*

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.