

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **505**
Registrar's No. **31**

FILED JAN 27 1953

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008**

143
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY CALLOWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CALLOWAY	
b. CITY (If outside corporate limits, write RURAL and give township) FULTON		c. LENGTH OF STAY (in this place) 4 M - 16 DA	
d. FULL NAME OF HOSPITAL OR INSTITUTION STATE HOSPITAL NO 1.		e. STREET ADDRESS (If rural, give location) 0143	

3. NAME OF DECEASED (Type or Print) a. (First) OLIVE	b. (Middle) O	c. (Last) VEMER	4. DATE OF DEATH (Month) (Day) (Year) JAN 22 1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH FEBRUARY - 17 1887 85	9. AGE (in years last birthday) (Month) (Day) (Year) 11 5	IF UNDER 14 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) keeping own home		10b. KIND OF BUSINESS OR INDUSTRY keeping own home		11. BIRTHPLACE (City and State or Foreign Country) CALLOWAY COUNTY MO	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME JAMES XXXXXXXX MAC KLICE	13b. MOTHER'S MAIDEN NAME ELIZABETH NICHOLS	14. NAME OF HUSBAND OR WIFE ROBERT VEMER
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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 Hospital Records	ADDRESS Fulton Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1-19-53
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia.	DUE TO (b) _____		
ANTECEDENT CAUSES	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Conditions contributing to the death but not related to the disease or condition causing death. 491X			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) Fulton Missouri
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-19-53** to **Jan-22-53**, 19____, that I last saw the deceased alive on **Jan-22/53**, 19____, and that death occurred at **6:10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Maury Fowler M.D.	Degree or Title) _____	23b. ADDRESS Fulton Missouri	23c. DATE SIGNED 1/22/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 24 1953	24c. NAME OF CEMETERY OR CREMATORY Millersburg Cem.	24d. LOCATION (City, town, or county) (State) Millersburg Mo
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DATE REC'D BY LOCAL REG. Jan-22-1953	REGISTRAR'S SIGNATURE Martha Lawrence	426	FUNERAL DIRECTOR'S SIGNATURE Carver Funeral Service	ADDRESS Columbia Mo
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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.....
Signature of Student Embalmer

Signed..... *Thas L. Young*

Licensed Embalmer No. *413*

P. O. Address *Columbia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.