

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8636

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 119

1. PLACE OF DEATH a. CITY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>Community Nursing Home</u> <u>Kirksville, Mo.</u>		c. LENGTH OF STAY (In this place) <u>21 days</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home #1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u> <u>0013</u>	
		d. STREET ADDRESS (If rural, give location) <u>South Main</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Isabelle</u> b. (Middle) <u>Ashford</u> c. (Last) <u>Stokes</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 3, 1953</u>
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5. SEX <u>F</u> <u>3</u>	6. COLOR <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 18, 1870</u>	9. AGE (In years) (Month) (Day) (Year) <u>82</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Gallatin, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Henry Lee</u>	13b. MOTHER'S MAIDEN NAME <u>Marth Jane</u>	14. NAME OF HUSBAND OR WIFE <u>X</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Emma Coby, Kirksville, Mo.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Septis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchial Pneumonia</u> DUE TO (c) <u>Myocardial Heart Disease</u>		
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 <u>491X</u>	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)
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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?
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22. I hereby certify that I attended the deceased from March 15, 1953 to April 3, 1953, that I last saw the deceased alive on March 5, 1953, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <u>David W. Boone MD</u>	23b. ADDRESS <u>Kirkville, MO.</u>	23c. DATE SIGNED <u>4-4-53</u>
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24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/6/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	24d. LOCATION (City, town, or county) (State) <u>Kirkville, MO.</u>
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DATE REC'D BY LOCAL REG. <u>4-4-53</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kirkville, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *Richard H. Bandall*.....

Licensed Embalmer No. *4866*.....

P. O. Address *Fairsville, 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.