

FILED APR 6 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8790**

BIRTH NO.		REG. DIST. NO. 38	PRIMARY REG. DIST. NO. 5122	Registrar's No. 93
1. PLACE OF DEATH a. COUNTY Boone			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural--Rocky Fork		c. LENGTH OF STAY (In this place) 55 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural--Rocky Fork 1100
d. FULL NAME OF HOSPITAL OR INSTITUTION RFD 1--Sturgeon Mo			d. STREET ADDRESS (If rural, give location) RFD 1--Sturgeon 0	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) WASHINGTON c. (Last) BREEDLOVE			4. DATE OF DEATH (Month) (Day) (Year) 3-22-53	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-6-1873	9. AGE (In years last birthday) 79
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) Boone County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME George Breedlove		13b. MOTHER'S MAIDEN NAME Barnes	14. NAME OF HUSBAND OR WIFE Harriet Maiden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs. Wm. Washington Breedlove, Sturgeon	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Poor weight		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 3'3 4/8		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)		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 March 19, 1953 , to March 22, 1953 , that I last saw the deceased alive on March 17, 1953 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree of title) W. M. Palmer, M.D.			23b. ADDRESS Sturgeon, Mo	
23c. DATE SIGNED 3/23-53				
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-24-53	24c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery	24d. LOCATION (City, town, or county) (State) Boone County, Missouri
DATE REC'D BY LOCAL REG. April 1 1953		REGISTRAR'S SIGNATURE Mrs. R. E. Palmer		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Bill Maden, Sturgeon, Missouri

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

APR 7 1953

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 Bill Meader

Licensed Embalmer No. 4876

P. O. Address Centralia, Missouri

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.