

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3766

State File No.

BIRTH NO. FILED FEB 15 1954 REG. DIST. NO. 364 PRIMARY REG. DIST. NO. 4531 Registrar's No. 15

1090
4

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

1. PLACE OF DEATH a. COUNTY Warren			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) OR TOWN Warrenton		c. LENGTH OF STAY (in this place) 17 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Holt Summit, Mo. 0140				
d. FULL NAME OF HOSPITAL OR INSTITUTION Katie Jane Memorial Home			d. STREET ADDRESS (If rural, give location) 1				
3. NAME OF DECEASED (Type or Print) Robert S. Amos			4. DATE OF DEATH (Month) (Day) (Year) 2 7 54				
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 5/10/78	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 9 Days 3	IF UNDER 24 HRS. Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 0 Missouri			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Benjamin Amos		13b. MOTHER'S MAIDEN NAME Sarah Roark			
14. NAME OF HUSBAND OR WIFE Ida (Deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT'S SIGNATURE OR NAME Ben E. Amos		ADDRESS Canton, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia related Hypertension ANTECEDENT CAUSES DUE TO (b) Hodgkin's disease DUE TO (c) Cerebral embolus embolism II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH 5 days	
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. 22, 1954 , to Feb. 7, 1954 , that I last saw the deceased alive on Feb. 7, 1954 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) D. Harold H. H. H.			23b. ADDRESS Warrenton Mo		23c. DATE SIGNED 2-8-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 1-9-54		24c. NAME OF CEMETERY OR CREMATORY ENLDE CEM. Russellville		24d. LOCATION (City, town, or county) (State) Mo	
DATE REC'D BY LOCAL REG. 2-11-54		REGISTRAR'S SIGNATURE Floyd Logan 421		25. FUNERAL DIRECTOR'S SIGNATURE McSteffens ADDRESS Russellville 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 *G. W. Steffens*

Licensed Embalmer No. 2307

P. O. Address Russellville 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.