

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15102

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 136

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>                   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u> |   |
| b. CITY OR TOWN <u>FULTON</u>                                    | c. LENGTH OF STAY (in this place) township) <u>1 WY</u> | c. CITY OR TOWN <u>JACKSON TWP</u>   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Callaway Hospital</u> |   | e. STREET ADDRESS (If rural, give location) <u>R.F.D. Ruxvasse 0140</u>  |   |

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|---|--|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>CHARLEY</u>  | b. (Middle) <u>CARSON</u>                        | c. (Last) <u>DEARDORFF</u>   | 4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 27 / 54</u> |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>White</u>                    | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>        | 8. DATE OF BIRTH <u>FEB 24 / 1883</u>                    |
| 9. AGE (In years last birthday) <u>71</u>   | if UNDER 1 YEAR Months _____ Days _____          | if UNDER 11 HRS. Hours _____ Min. _____                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Callaway County Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                  |

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME <u>Jessie P. Deardorff</u>  | 13b. MOTHER'S MAIDEN NAME <u>AMANDA HAYES</u> | 14. NAME OF HUSBAND OR WIFE <u>LIZZIE DEARDORFF</u>                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>No</u>             | 17. INFORMANT'S SIGNATURE OR NAME <u>Fred Beard of Ruxvasse Mo</u> ADDRESS _____ |

|   |   |                |  |
|---|---|----------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |                | INTERVAL BETWEEN ONSET AND DEATH<br><u>5/19/54</u><br><u>years</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ac. cerebral hemorrhage</u>   |                |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>arteriosclerosis</u><br>DUE TO (c) _____ |                |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Taminal Hypostatic Pneumonia.</u>  |   | <u>5/26/54</u> |  |

|                              |  |  |
|------------------------------|--|--|
| 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 4/10, 1954, to 5/27, 1954, that I last saw the deceased alive on 5/27, 1954, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

|   |                                 |                                 |
|---|---------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Henry D. Smith MD</u> | 23b. ADDRESS <u>Fulton, Mo.</u> | 23c. DATE SIGNED <u>5/29/54</u> |
|---|---------------------------------|---------------------------------|

|   |                            |  |  |
|---|----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>MAY 29/54</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Ruxvasse</u> | 24d. LOCATION (City, town, or county) (State) <u>Ruxvasse Mo</u> |
|---|----------------------------|--|--|

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|---|--|---|
| DATE REC'D BY LOCAL REG. <u>May 29 1954</u> | REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> <u>426</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice P. H. Fulton</u> ADDRESS <u>Fulton Mo</u> |
|---|--|---|

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

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 *Wm C Stewart* .....

Licensed Embalmer No. *372*

P. O. Address *Fulton* .....

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.