

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23434

BIRTH NO. _____ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JEFFERSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, write RURAL and give township) HILLSBORO		c. CITY (If outside corporate limits, write RURAL and give township) HILLSBORO	
d. FULL NAME OF HOSPITAL OR INSTITUTION CEDAR GROVE NURSING HOME		d. STREET ADDRESS (If rural, give location) 0 500	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) WASHINGTON c. (Last) CAREY		4. DATE OF DEATH (Month) (Day) (Year) JULY 20 1954	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH DEC. 29 1869
9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	11. BIRTHPLACE (State or foreign country) COFFEEN ILL.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY ?	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JAMES W CAREY		13b. MOTHER'S MAIDEN NAME UNK	14. NAME OF HUSBAND OR WIFE UNK
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. ?	17. INFORMANT'S SIGNATURE OR NAME ADDRESS JAMES O. CAREY SAN FRANCISCO
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) Heat exhaustion. INTERVAL BETWEEN ONSET AND DEATH 48 hours ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility with psychosis. One year.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 050 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 Aug 22, 1954 , to July 20, 1954 , that I last saw the deceased alive on July 20, 1954 , and that death occurred at 4:56 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Thomas A. Donnell M.D.		23b. ADDRESS Osato, Mo.	
23c. DATE SIGNED 7-21-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE July 21	24c. NAME OF CEMETERY OR CREMATORY COFFEEN CEM.	24d. LOCATION (City, town, or county) (State) COFFEEN ILL.
DATE REC'D BY LOCAL REG. 7-21-54	REGISTRAR'S SIGNATURE Kathleen Marsden	5. FEDERAL DIRECTOR'S SIGNATURE ADDRESS Samuel B. Atchley Osato, Mo.	

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

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

JUL 28 1954

AUG 1 1954

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 _____

Donnell B. Dietrich

Licensed Embalmer No. 4104

P. O. Address Debate 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.