No. 300
10-48

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

FILED OCT 11 1954

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30190

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4466 Registrar's No. 56

1. PLACE OF DEATH
a. COUNTY: DeKalb
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weatherby
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home In town

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: DeKalb
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weatherby
d. STREET ADDRESS (If rural, give location): in town

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3. NAME OF DECEASED (Type or Print): a. (First) Lois b. (Middle) Irene c. (Last) Whiteaker

4. DATE OF DEATH: (Month) 9 (Day) 19 (Year) 54

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 11-31-1926

9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months 9, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and State or Foreign Country): Weatherby Mo

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Covel Whiteaker

13b. MOTHER'S MAIDEN NAME: Irene Roloson

14. NAME OF HUSBAND OR WIFE: None

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.: XXXXXXXXX

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Covel Whiteaker Weatherby

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Palsy Congenital

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.

INTERVAL BETWEEN ONSET AND DEATH: 27 yrs

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION 334X

20. AUTOPSY? YES ☐ NO ☐

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) _____ m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 9/14, 1954, to 9/19, 1954, that I last saw the deceased alive on 9/18, 1954, and that death occurred at 3:00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Dr Harold Fowler MD

23b. ADDRESS: Maysville MO

23c. DATE SIGNED: 9/20/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-21-54

24c. NAME OF CEMETERY OR CREMATORY: Hopewell

24d. LOCATION (City, town, or county) (State): Weatherby Mo

DATE REC'D BY LOCAL REG. 9-27-54

REGISTRAR'S SIGNATURE: Rachel Rawlins 82-0

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Mayesville 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 John L. Brown

Licensed Embalmer No. 3933

P. O. Address Maysville 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.