

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31187

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 154

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chellieathe</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chellieathe mo</u>	
c. LENGTH OF STAY (in this place) <u>52 yr</u>		d. STREET ADDRESS (If rural, give location) <u>118 Wilson 0590</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>118 Wilson</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) <u>Benjamin</u> c. (Last) <u>Cesar</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-20-54</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-19-1871</u>
9. AGE (In years last birthday) <u>83</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stockman</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and State or Foreign Country) <u>Hale Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Benjamin Cesar</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ghule</u>	
14. NAME OF MARRIED OR WIFE <u>Sue Cesar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT'S SIGNATURE OR NAME (In address) <u>Mr. Herman W. Shelt, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Cerebral arteriosclerosis</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		DUE TO (b) _____	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypostatic pneumonia</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>334X</u>	
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 <u>9-5-1954</u> to <u>9-18-1954</u> , that I last saw the deceased alive on <u>9/18/1954</u> , and that death occurred at <u>3460 m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>MD Dr. W. M. Dr. W. M.</u>		23b. ADDRESS <u>Chellieathe Mo</u>	
23c. DATE SIGNED <u>9/21/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-22-54</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>		24d. LOCATION (City, town, or county) (State) <u>Chellieathe Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-21-54</u>		REGISTRAR'S SIGNATURE <u>Francis B. Neil</u> ADDRESS <u>Chellieathe Mo</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Shelt</u>		ADDRESS <u>Chellieathe Mo</u>	

**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 \_\_\_\_\_

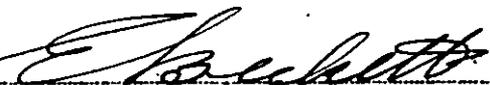
Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. 3227

P. O. Address Chillicothe, 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.