

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38485

State File No.

FILED NOV 23 1954

BIRTH NO. 134 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 350

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN <u>Rural St. Francisburg, Mo.</u>		c. CITY OR TOWN <u>Belgrade</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>1 day</u>		e. STREET ADDRESS (If rural, give location) <u>11001</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mineral Area Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>W.</u>	c. (Last) <u>William</u>	4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>14</u> (Year) <u>1954</u>
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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>Jan 8 1877</u>	9. AGE (In years last birthday) <u>77</u> Months <u>10</u> Days <u>6</u>	10. UNDER 1 YEAR Hours <u>0</u> Min. <u>0</u>	11. UNDER 12 HRS. Hours <u>0</u> Min. <u>0</u>
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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>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Palmer Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jim William</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lila William</u>
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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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ulliel William DeLoe Mo.</u>	ADDRESS <u>Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u>		<u>2 min.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u> DUE TO (c) <u>fracture L1 vertebra.</u>		<u>11 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>E8354 35</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>farm</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11/3/54 9:45</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto Accident</u>
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22. I hereby certify that I attended the deceased from 11/3/54, 1954, to 11/14/54, that I last saw the deceased alive on 11/12/54, 1954, and that death occurred at 11:57 A. M., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul J. Koen</u> (Degree or title) <u>MOA</u>	23b. ADDRESS <u>Farrington, Mo.</u>	23c. DATE SIGNED <u>11/14/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-16-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>East Creek Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Washington Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Nov. 14, 1954</u>	REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Luther Spuh</u>	ADDRESS <u>Peters Mo.</u>
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(Licensed Embalmers' Statement on Reverse Side)

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

NOV 29

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.....
Murphy Sparks

Licensed Embalmer No. *4336*
P. O. Address *Madison*

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.