

FILED JAN 4 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40505

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5368 Registrar's No. 16

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

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Daviess  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Daviess  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) Coffey, Missouri |  | c. CITY OR TOWN Coffey   |  |
| c. LENGTH OF STAY (In this place) 10 years  |  | d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION. — Salem Ins                              |  | e. STREET ADDRESS (If rural, give location) — 0310   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) Nannie Alice O'Hare b. (Middle) c. (Last) |  |  | 4. DATE OF DEATH (Month) (Day) (Year) 11-20-1954 |  |  |
|---|--|--|--|--|--|

|               |  |                        |  |  |  |                              |  |                                    |  |                         |  |                       |  |                        |  |                       |  |
|---------------|--|------------------------|--|--|--|------------------------------|--|------------------------------------|--|-------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|
| 5. SEX Female |  | 6. COLOR OR RACE White |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed |  | 8. DATE OF BIRTH Jan 4, 1868 |  | 9. AGE (In years last birthday) 86 |  | 10. UNDER 1 YEAR Months |  | 10. UNDER 1 YEAR Days |  | 10. UNDER 1 YEAR Hours |  | 10. UNDER 1 YEAR Min. |  |
|---------------|--|------------------------|--|--|--|------------------------------|--|------------------------------------|--|-------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|

|   |  |   |  |  |  |                                     |  |
|---|--|---|--|--|--|-------------------------------------|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |  | 10b. KIND OF BUSINESS OR INDUSTRY Housekeeper |  | 11. BIRTHPLACE (City and State or Foreign Country) McFall, Mo. |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |  |
|---|--|---|--|--|--|-------------------------------------|--|

|                                   |  |                                     |  |  |  |
|-----------------------------------|--|-------------------------------------|--|--|--|
| 13a. FATHER'S NAME David M. Heath |  | 13b. MOTHER'S MAIDEN NAME Jane Kerr |  | 14. NAME OF HUSBAND OR WIFE Hugh Elwood O'Hare |  |
|-----------------------------------|--|-------------------------------------|--|--|--|

|  |  |                              |  |   |  |
|--|--|------------------------------|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No |  | 16. SOCIAL SECURITY NO. None |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter H. O'Hare, Coffey, Mo. |  |
|--|--|------------------------------|--|---|--|

|   |  |   |  |  |  |                                  |  |
|---|--|---|--|--|--|----------------------------------|--|
| 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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Dementia</i>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |  |                                  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |  |  |                                  |  |

|                        |  |                                  |  |  |  |
|------------------------|--|----------------------------------|--|--|--|
| 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) m. |  | 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 Nov 16, 1954, to Nov 19, 1954, that I last saw the deceased alive on Nov 19, 1954, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

|  |  |              |  |                  |  |
|--|--|--------------|--|------------------|--|
| 23a. SIGNATURE <i>J. B. Graham</i> (Degree or title) |  | 23b. ADDRESS |  | 23c. DATE SIGNED |  |
|--|--|--------------|--|------------------|--|

|  |  |                    |  |  |  |   |  |
|--|--|--------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial |  | 24b. DATE 11-23-54 |  | 24c. NAME OF CEMETERY OR CREMATORY Coffey Cemetery |  | 24d. LOCATION (City, town, or county) (State) Coffey, Mo. |  |
|--|--|--------------------|--|--|--|---|--|

|                                   |  |  |  |   |  |
|-----------------------------------|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. 12-28-54 |  | REGISTRAR'S SIGNATURE <i>Regina M. Engbert</i> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Louise... Pattonburg, Mo.</i> |  |
|-----------------------------------|--|--|--|---|--|

JAN 1 1955

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

Signature *Louis Quest*

Licensed Embalmer No. *409*

P. O. Address *Waltham*

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.