

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED MAR 8 1955

BIRTH NO. _____ REG. DIST. NO. **70** PRIMARY REG. DIST. NO. **5278** Registrar's No. **9**

230

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

1. PLACE OF DEATH a. COUNTY Clark		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Clark	
b. CITY OR TOWN Rural Jackson	c. LENGTH OF STAY (in this place) 150 years	c. CITY OR TOWN Rural	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (if not in hospital or institution, give street address or location) Thomas William Doran		e. STREET ADDRESS (If rural, give location) Jackson Twp 10230	

3. NAME OF DECEASED (Type or Print) a. (First) Thomas b. (Middle) William c. (Last) Doran	4. DATE OF DEATH (Month) (Day) (Year) 2-26-55
---	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 5-1881	9. AGE (in years last birthday) 73	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 2 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	------------------------------------	---	---	--

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

13a. FATHER'S NAME William Doran	13b. MOTHER'S MAIDEN NAME Katherine O'Shea	14. NAME OF HUSBAND OR WIFE Mary J. Baker
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____
--	-------------------------------	---

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		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate		
	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.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 177X	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.) 1	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 19, 1954**, to **Feb. 26, 1955**, that I last saw the deceased alive on **Feb 26, 1955**, and that death occurred at **11:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE D. C. Todd (Degree or title) 61	23b. ADDRESS Williamstown Mo	23c. DATE SIGNED 3/2/1955
--	-------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-28-55	24c. NAME OF CEMETERY OR CREMATORY St Patrick Cem.	24d. LOCATION (City, town, or county) (State) Clark Co Mo
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. 3/4-55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Fred J. Kalle ADDRESS Kahoka Mo
--	--	--

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 *Fred J. Karle*.....

Licensed Embalmer No. *1023*

P. O. Address *Kahala*.....

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.