

FILED OCT 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32220**

| | | | | | | | | |
|--|---|--|---|---|---|--|---|--|
| BIRTH NO. | | REG. DIST. NO. 38 | | PRIMARY REG. DIST. NO. 5122 | | Registrar's No. 280 | | |
| 1. PLACE OF DEATH a. COUNTY Boone | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone | | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) Rural Rockyfork | | c. LENGTH OF STAY (In this place) 3 yrs | | c. CITY OR TOWN Hallsville | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | | e. STREET ADDRESS (If rural, give location) Rockyfork Township | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Chester | | | b. (Middle) | | c. (Last) Ancell | | 4. DATE OF DEATH (Month) (Day) (Year) Oct 20 1955 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH 9 - 27 - 1897 | | 9. AGE (In years last birthday) 58 | IF UNDER 1 YEAR Months 0 Days 29 | IF UNDER 24 HRS. Hours - Min. - | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Factory | | 11. BIRTHPLACE (City and State or Foreign Country) Howard County, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Samuel Ancell | | | 13b. MOTHER'S MAIDEN NAME Catherine Lyle | | 14. NAME OF HUSBAND OR WIFE Elsie Goslin | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Chester Ancell, Hallsville, Mo | | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease | | | | | INTERVAL BETWEEN ONSET AND DEATH Unk | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis | | | | | Unk | | |
| | DUE TO (c) H2000 | | | | | | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerosis | | | | | Unk | | |
| 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) (Min.) | | 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 Sept 10 , 19 55 , to 10/20 , 19 55 , that I last saw the deceased alive on 10/16 , 19 55 , and that death occurred at 3:15 P m., from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Robert L. Ward M.D. | | | | | 23b. ADDRESS Centralia Mo | | 23c. DATE SIGNED 10/22/55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 1955 Oct. 22 | 24c. NAME OF CEMETERY OR CREMATORY Locust Grove | | 24d. LOCATION (City, town, or county) (State) Sturgeon, Boone Co, Mo. | | | |
| DATE REC'D BY LOCAL REG. Oct. 24 1955 | | REGISTRAR'S SIGNATURE Mrs R.E. Palmer | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bill Meador Centralia, Missouri | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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 *Bill J. Meador*.....
Licensed Embalmer No. *401*.....
P. O. Address *Centralia, Mo.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If not 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.