

FILED NOV 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **34170**

073004

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **245** PRIMARY REG. DIST. NO. **5836** Registrar's No. **108**

1. PLACE OF DEATH a. COUNTY <b>Newton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>McDonald</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Neosho: (Rural)</b>		c. CITY OR TOWN <b>Anderson</b>	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) <b>3 Months</b>		e. STREET ADDRESS (If rural, give location) <b>Rt. #. 3, 7 miles east.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Smith Nursing Home</b>		3. NAME OF DECEASED a. (First) <b>William</b> b. (Middle) <b>Clayborn</b> c. (Last) <b>Painter</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>October 28, 1955</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>July 14, 1878</b>		9. AGE (In years last birthday) <b>77</b> Months <b>3</b> Days <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Jim Painter</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Jane Hix</b>	
14. NAME OF HUSBAND OR WIFE <b>Sarah E. Painter</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Sarah E. Painter</b> ADDRESS <b>Anderson Rt. 3</b>	
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) <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> ANTECEDENT CAUSES DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>331X</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Calcification of left kidney.</b>	
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)		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 <b>10/26/55</b> , 19, to <b>10/28/55</b> , 19, that I last saw the deceased alive on <b>10/27/55</b> , 19, and that death occurred at <b>2 P.M.</b> m., from the causes and on the date stated above.	
23a. SIGNATURE <b>H. Bush D.D.</b> (Degree or title)		23b. ADDRESS <b>Anderson Mo</b>	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>10/28/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Tracy Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Rt. 3 Anderson, Missouri.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Carl R. Anderson, Missouri</b> ADDRESS	
DATE REC'D BY LOCAL REG. <b>10-31-55</b>		REGISTRAR'S SIGNATURE <b>Melvin C. Bowman</b> 223- (Licensed Embalmer's Statement on Reverse Side)	

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

NEWTON COUNTY HEALTH UNIT

**RECEIVED**

District Health Officer No. \_\_\_\_\_

District File No. \_\_\_\_\_

Date Filed **NOV 4 1955**

NEOSHO, MISSOURI

**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 *Carl Rapp* \_\_\_\_\_

Licensed Embalmer No. *3458*

P. O. Address *Anderson, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.