Health, Welfare Public Service

300 1-56

FILED NOV 21 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 36898

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 347

1. PLACE OF DEATH a. COUNTY Adair	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Kirksville 8013 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) K. O. H. — Length of stay in 1b 1 da	d. STREET ADDRESS (If outside, give location) 201 S. Marion St., — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Maude Middle S Last Painter

4. DATE OF DEATH Month Day Year Nov. 15, 1956

5. SEX F 1

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 2

8. DATE OF BIRTH Apr. 21, 1877

9. AGE (In years last birthday) 19 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and state or country) Macon County, Mo. 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joe M. A. Vaughan

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) x

16. SOCIAL SECURITY NO. x

17. INFORMANT Address Paul Painter, Urbana, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Infarction

DUE TO (c) Coronary Thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Due to Arterio-Sclerotic Hard disease 4200

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11-14-56, to 11-15-56 and last saw her/him alive on 11-14-56

Death occurred at 7:02 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) David W. Boone MO. 2

22b. ADDRESS Kirksville, Mo.

22c. DATE SIGNED 11-15-56

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11/19/56

23c. NAME OF CEMETERY OR CREMATORY Lake Side Cemetery

23d. LOCATION (City, town, or county) (State) Chariton County, Mo.

24. FUNERAL DIRECTOR [signature] ADDRESS Kirksville, Mo.

25. DATE RECD. BY LOCAL REG. 11-17-56

26. REGISTRAR'S SIGNATURE Kate Lambert

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Kenneth E. Hayes.....

Licensed Embalmer No. 489.

P. O. Address Kirksville,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.