

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34669

STATE FILE NUMBER

FILED OCT 1 1957

Registration District No. 373 Primary Registration District No. 4546 Registrar's No. 2637

300  
-57

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARSHFIELD MO</u>		c. CITY OR TOWN <u>MARSHFIELD MO</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>540 MAPAE</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN WESLEY DAILEY</u>		4. DATE OF DEATH <u>SEPT 15 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>TOM DAILEY</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY BRADSHAW</u>		14. NAME OF HUSBAND OR WIFE <u>CHARA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CHARA DAILEY</u>		Address <u>MARSHFIELD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>			<u>10 years</u>
DUE TO (c) <u>Hypertensive Heart disease</u>			<u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General arteriosclerosis, Nephritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour · Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
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 <u>2 Nov. 1952</u> to <u>15 Sept 57</u> and last saw her alive on <u>24 Aug 57</u> Death occurred at <u>5:40 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>T. M. Macdonnell, MD</u>		22b. ADDRESS <u>Marshfield, Mo.</u>	
22c. DATE SIGNED <u>16 Sept 57</u>			
23a. BURIAL, CREMATION, REMOVAL? (Specify) <u>BURIAL</u>		23b. DATE <u>9-17-1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD</u>		23d. LOCATION (City, town, or county) (State) <u>MARSHFIELD MO</u>	
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS</u>		25. DATE RECD. BY LOCAL REG. <u>9-20-57</u>	
ADDRESS <u>MARSHFIELD MO</u>		26. REGISTRAR'S SIGNATURE <u>J. Strained</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard instruments and wear gloves. All diseases in Part I must be causally related.

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 *R. W. Barber* .....

Licensed Embalmer No. *384* .....

P. O. Address *W. K. Grove* .....

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.