Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-028625
STATE FILE NUMBER

Filed SEP 8 1958 Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 103

1. PLACE OF DEATH
a. COUNTY Cooper
b. CITY OR TOWN Boonville — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Joseph Hospital — Length of stay in Ib 2 Da

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cooper
c. CITY OR TOWN Boonville — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Rural — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First: George Middle: E Last: Meredith
4. DATE OF DEATH Month: August Day: 30 Year: 1958
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Feb.14 1880
9. AGE (In years last birthday): 78 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Cooper Co.Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Henry L.Meredith
13b. MOTHER'S MAIDEN NAME: Sarah McGruder
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Della Meredith, Slater, Missouri

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) Apoplexy Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertention
DUE TO (c) Arteriosclerosis 33/X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 Aug.28,58, to Aug.30,58 and last saw her/him alive on Aug.30,58
Death occurred at 10:00 p.m. 19; m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L.L.Chamberlain MD
22b. ADDRESS Boonville Missouri
22c. DATE SIGNED 8-30-58

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 9-1-58
23c. NAME OF CEMETERY OR CREMATORY: Pilot Grove
23d. LOCATION (City, town, or county) (State): Pilot Grove Mo.

24. FUNERAL DIRECTOR: B.W.Thacher ADDRESS: Boonville, Missouri
25. DATE RECD. BY LOCAL REG.: 9-1-58
26. REGISTRAR'S SIGNATURE: D.B.Hooper

(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 causally related.

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 embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Perry W. Shaler

Licensed Embalmer No. 3944

P. O. Address Boonville 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.