

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000117

STATE FILE NUMBER

JAN 22 1959 Registration District No. 11

Primary Registration District No. 4025

Registrar's No. 1

300 3  
1-57

1. PLACE OF DEATH a. COUNTY <b>BARRY</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Newton</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Wheaton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fairview 0730</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Barber Shop.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>R.F.D.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FINIS</b> Middle <b>OREN</b> Last <b>DANIELS</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov-5-1898</b>	9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR: Months <b>2</b> Days <b>1</b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER-AND-CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>William J. Daniels</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Santee</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Daniels</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>489-16-3589</b>	17. INFORMANT <b>Florence Daniels</b> Address <b>Fairview Mo RFD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>coronary thrombosis</b>					<b>15 min.</b>
DUE TO (c) <b>Arteriosclerosis</b>					<b>10 yrs.</b>
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 <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.) <b>4201</b>		
20c. TIME OF INJURY Hour <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <b>2<sup>25</sup> p.m. 1/6/59</b> to <b>2<sup>42</sup> p.m. 1/6/59</b> and last saw him alive on <b>1/6/59</b> Death occurred at <b>2:42 P.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Fred R. Clark M.D. - 2</b>			22b. ADDRESS <b>Wheaton, Mo.</b>		22c. DATE SIGNED <b>1/8/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 9-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dice Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Newton Co. Mo.</b>
24. FUNERAL DIRECTOR <b>McQueen Funeral Home, Wheaton Mo</b>			25. DATE RECD. BY LOCAL REG. <b>1-12-1959</b>	26. REGISTRAR'S SIGNATURE <b>Grace Williams</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Paul D. Heubert

Licensed Embalmer No. 4576  
P. O. Address... Cassville, 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.