

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018740

STATE FILE NUMBER

FILED JUN 10 1959

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 69

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| 1. PLACE OF DEATH a. COUNTY <u>PULASKI</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WAYNESVILLE MO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>NIANGUA MO RI</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>GENERAL HOSP.</u> Length of stay in 1b <u>4 HRS</u> | | d. STREET ADDRESS (If outside, give location) <u>6 mi N.E.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>D</u> Last <u>ONEAL</u> | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1959</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR 13 1878</u> | 9. AGE (In years last birthday) <u>81</u> | 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) <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> | |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME <u>UNKNOWN</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>DOVIE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT Address <u>WALTER ONEAL NIANGUA MO RI</u> | |

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| 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>MYOCARDIAL FAILURE, ACUTE</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>YEARS.</u> <u>YEARS.</u> |
| DUE TO (b) <u>MYOCARDITIS, CHRONIC, C</u> | | | |
| DUE TO (c) <u>MYOCARDIAL INSUFFICIENCY</u> | | | |
| 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"/> |

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| 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.) _____ |
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| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. | 20d. INJURY OCCURRED WHILE AT WORK <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 _____ |
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| 21. I attended the deceased from <u>1 A.M. 7 MAY 59</u> to <u>DEATH</u> and last saw <u>him</u> alive on <u>MAY 7 - 1959</u> . Death occurred at <u>5207</u> on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u> | 22b. ADDRESS <u>RICHLAND, MO.</u> | 22c. DATE SIGNED <u>5-12-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>5-10-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CONWAY</u> | 23d. LOCATION (City, town, or county) (State) <u>CONWAY MO</u> |
|--|----------------------------|--|--|

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| 24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD MO</u> | 25. DATE RECD. BY LOCAL REG. <u>5-30-59</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

00-57

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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

Licensed Embalmer No. 38

P. O. Address Mt. 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.