

FILED MAY 9 1955

STANDARD CERTIFICATE OF DEATH

State File No. 11091

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 446

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarksdale	
c. LENGTH OF STAY (in this place) 1 month		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) ARTHUR	b. (Middle) JOSEPH	c. (Last) SAMPLE	April 25, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 9, 1886	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME George Sample		13b. MOTHER'S MAIDEN NAME Mary Golledge		14. NAME OF HUSBAND OR WIFE Mabel Sample	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 500-07-2061		17. INFORMANT'S SIGNATURE OR NAME Mabel Sample, Clarksdale, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident			5 weeks
		ANTECEDENT CAUSES			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR		

22. I hereby certify that I attended the deceased from Mar 29, 1955, to Apr 25, 1955, that I last saw the deceased alive on Apr 25, 1955, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. Carpenter M.D.		23b. ADDRESS 902 Edmond St., St. Joseph, Mo.		23c. DATE SIGNED 5/3/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr 28, 1955		24c. NAME OF CEMETERY OR CREMATORY, LOCATION (City, town, or county) (State) Clarksdale Cemetery, Clarksdale, Mo.	

DATE REC'D BY LOCAL REG. May 3, 1955		REGISTRAR'S SIGNATURE Esther M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Brown	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

500 142 100

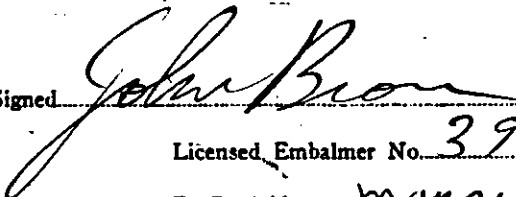
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer

Signed 

Licensed Embalmer No. 3933

P. O. Address. Maysville, 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 this body is not embalmed, fact should be so stated above.