

No. 2  
M-5-43  
7-5-17-39  
I X3667

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27068**

**FILED SEP 10 1947**

Registration District No. \_\_\_\_\_ Primary Registration District No. **4110**

Registrar's No. **43**

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

**1. PLACE OF DEATH:** *Chariton*

(a) County *Chariton*

(b) City or town *Salisbury*

(c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community *whole life* (Specify whether \_\_\_\_\_)

years, months or days

**3. (a) PRINT FULL NAME** *William Richard Dameron*

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex *Male* 5. Color of race *Col*

6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *Sept 10 1890*

(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day

*77 1 16* hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) *Mo* (State or foreign country)

10. Usual occupation *laborer*

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name *Logan Dameron*

13. Birthplace *Chariton Mo* (City, town, or county) (State or foreign country)

14. Maiden name *Annie Ewing*

15. Birthplace *Chariton Mo* (City, town, or county) (State or foreign country)

16. (a) Informant *J. W. Dameron*

(b) Address *Salisbury*

17. (a) *Burial* (Burial, cremation, or recovery) (b) Date thereof *7 27 47* (Month) (Day) (Year)

(c) Place: burial or cremation *Salisbury Mo*

18. (a) Signature of funeral director *Geo Blunkmeyer*

(b) Address *Salisbury Mo*

19. (a) *7/25/47* (Date received local registrar) (b) *S. S. Stanton* (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State *Missouri* (b) County *Chariton*

(c) City or town *Salisbury* (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month *July* day *24* year *18* hour *18* minute *20* M.

21. I hereby certify that I attended the deceased from *July 18* to *July 24* 19*47* that I last saw him alive on *July 23* 19*47* and that death occurred on the date and hour stated above.

Immediate cause of death *cardiac failure*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations: \_\_\_\_\_ Of autopsy: \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature *S. S. Stanton* (M. D. or other) \_\_\_\_\_

Address *Salisbury Mo* Date signed *7/25/47*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-9-17

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Chas B. Winkelmeyer

Licensed Embalmer No. 3842

P. O. Address Salisbury 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.