S. No. 300
Rev. 10-48

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

FILED DEC 28 1948

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39925

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 2023 Registrar's No. 257

1. PLACE OF DEATH
a. COUNTY: Henry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clinton
c. LENGTH OF STAY (in this place): 2 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wetzel Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St, Clair
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osceola (Rural)
d. STREET ADDRESS (If rural, give location): ~~Clinton~~ Missouri.

3. NAME OF DECEASED (Type or Print): a. (First) Jacob b. (Middle) Simpson c. (Last) Helmick

4. DATE OF DEATH (Month) (Day) (Year): 12-15-48

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	never Married	12-29-1870	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Memory Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Nathan Helmick
13b. MOTHER'S MAIDEN NAME: Emaline Pace
14. NAME OF HUSBAND OR WIFE:

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.: None
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Mrs Mary M Knight Osceola Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock -

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture of 9-10-11 Dorsal Vertebra
Hemorrhage in Mediastinal
DUE TO (c) Span — Henry County

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

1170C-8

19a. DATE OF OPERATION: 28
19b. MAJOR FINDINGS OF OPERATION
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

20. AUTOPSY? YES ☒ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 15, 1948, *to* Dec 15, 1948, *that I last saw the deceased alive on* Dec 15, 1948 *and that death occurred at* 11:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jno S Mayfield MD
23b. ADDRESS: Clinton Mo
23c. DATE SIGNED: Dec 15-48

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-19-48
24c. NAME OF CEMETERY OR CREMATORY: Benton Green
24d. LOCATION (City, town, or county) (State): Rascoe Missouri

DATE REC'D BY LOCAL REG.: 12-20-48
REGISTRAR'S SIGNATURE: R R Kenney 126
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: F B Goodrich Osceola Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 11-48-1481
Date Filed 12-27-48

OCT 1949

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 Charles L. Fox

Licensed Embalmer No. 4610

P. O. Address Osceola, 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.

S. No. 12B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 257

1. PLACE OF DEATH:

(a) County Henry (b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jacob S. Helmick

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if living years

7. Birth date of deceased Dec 29, 1871
(Month) (Day) (Year)

8. AGE: Years 77 | Months | Days | If less than one day hr min.

9. Birthplace (City, town, or county) Scotia (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER FATHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident only
(b) Date of occurrence 12-15-48
(c) Where did injury occur? Osceola St Clair Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 93 L

23. Signature Geo D Wentz (M. D. or other) MD
Address Clinton Mo Date signed 1-4-49

SUPPLEMENTARY

S-39925