

FILED FEB 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3807

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 3076 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Nevada</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Nevada</u>	
c. LENGTH OF STAY (in this place) <u>unknown</u>		d. STREET ADDRESS (If rural, give location) <u>1300 West Hickory</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1300 West Hickory</u>		d. STREET ADDRESS (If rural, give location) <u>1300 West Hickory</u>	
3. NAME OF DECEASED a. (First) <u>Samuel</u> b. (Middle) <u>Grant</u> c. (Last) <u>Flagor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 18, 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>W</u>	8. DATE OF BIRTH <u>Ordered 20-1864-84</u>
9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Surveyor</u>	11. BIRTHPLACE (State or foreign country) <u>Circleville, Ohio</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Survey</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>E. J. Flagor</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Virginia</u>	
13b. MOTHER'S MAIDEN NAME <u>Jessie Heeler</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Virginia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (When, no. of months) (If yes, give war or dates of service)		17. INFORMANT'S SIGNATURE OR NAME <u>Hubert Flagor</u> ADDRESS <u>801 E. Broadway, H. Co. Mo.</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Hubert Flagor</u> ADDRESS <u>801 E. Broadway, H. Co. Mo.</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myo carditis</u>		DUE TO (b) <u>Don't know</u>		
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Advanced age</u>				

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Nevada, Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan 15, 1949</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>	

22. I hereby certify that I attended the deceased from Jan 15, 1949, to Jan 18, 1949, that I last saw the deceased alive on Jan 15, 1949 and that death occurred at about 11 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. Love MD</u> (Degree or title)	23b. ADDRESS <u>Nevada, Mo.</u>	23c. DATE SIGNED <u>1/21/49</u>
24a. BURIAL (Specify) _____	24b. DATE <u>Jan 20-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Moore Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>Nevada Missouri</u>

DATE REC'D BY LOCAL REG. <u>2-1-49</u>	REGISTRAR'S SIGNATURE <u>Kathryn H. Yancey</u>	331	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ferny Funeral Home</u> ADDRESS <u>Nevada, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

58
2-1-49

DEC 27 1949

DEC 28 1949

RECEIVED

District Health Officer No. 7,

District File Number L-49-16

Date Filed 2.7.49

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. 1760

P. O. Address New York 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.