

FILED JAN 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3845

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Benton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Revol Wash Sup. 4th House</u>	c. LENGTH OF STAY (In this place) <u>1 yr</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bentonville</u>	<u>8</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>		d. STREET ADDRESS (If rural, give location) <u>_____</u>	

3. NAME OF DECEASED (Type or Print) <u>CHARLES E. MEADOWS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 17 1949</u>		
a. (First)	b. (Middle)	c. (Last)			

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-25-1874</u>	9. AGE (In years if under 1 year last birthday) Months Days Hours Min. <u>74 0 28</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>St Charles Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>J. M. Meadows</u>	13b. MOTHER'S MAIDEN NAME <u>Theresa Knight</u>	14. NAME OF HUSBAND OR WIFE <u>Nancy Meadows</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital records Dept</u> ADDRESS <u>_____</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senile Deterioration</u>		<u>7</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac Insufficiency</u> DUE TO (c) <u>✓</u>		<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u>			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>✓</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>✓</u>
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22. I hereby certify that I attended the deceased from 4-7-, 1947, to 1-17-, 1949, that I last saw the deceased alive on 1-17-, 1949, and that death occurred at 12-15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. G. Wall</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>_____ Mo</u>	23c. DATE SIGNED <u>1-17-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Jan 17-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	24d. LOCATION (City, town, or county) (State) <u>Warsaw, Mo</u>
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DATE REC'D BY LOCAL REG. <u>Jan 17-49</u>	REGISTRAR'S SIGNATURE <u>Kathryn H. Jancus</u>	331	25. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Resh</u> ADDRESS <u>Warsaw, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

108

RECEIVED

District Health Officer No. 7;

District File Number 12-48-1658

Date Filed 1-24-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John J. Reese

Licensed Embalmer No. 4098

P. O. Address Whelan, 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.