

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3914

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>KIRKSVILLE</u> b. COUNTY <u>ADAIR</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MISSOURI</u>	
c. LENGTH OF STAY (in this place) <u>5 yrs</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>802 Hamilton</u>			

3. NAME OF DECEASED a. (First) <u>George</u> b. (Middle) <u>Janiel</u> c. (Last) <u>Steele</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-14-1949</u>		
5. SEX <u>M O</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>5-31-1869</u>		9. AGE (In years last birthday) <u>79</u>		If UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>ILL.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Greenberry Steele</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Ann Wilsey</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Alice Steele</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Samuel Steele - Hurdland Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>4 or 5 yrs</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Nephritis</u>				1 year	
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 type="checkbox"/> NO <input type="checkbox"/>	
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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) _____	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
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22. I hereby certify that I attended the deceased from Feb 12, 1949, to Feb 14, 1949, that I last saw the deceased alive on Feb 12, 1949, and that death occurred at 4 P m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. D. Garrison M.D.</u>		23b. ADDRESS <u>Hovinger Mo</u>		23c. DATE SIGNED <u>2-15-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-17-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Hovinger, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>2-17-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis C. Stapp Lawrence Mo</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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3

No. 300  
10.48

RECEIVED

District Health Officer No. 10

District File Number 249,334

Date Filed FEB 1 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.

Signed \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 40261

P. O. Address Clarence 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.