

FILED APR 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7892

BIRTH NO. _____ REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5370 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Daviess?</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Rural Union Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Union Township</u>	
c. LENGTH OF STAY (in this place) <u>2 yrs</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2400 DAVIESS CO. HOME</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>-Franklin-</u> c. (Last) <u>Everman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-22-49</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 19-1854</u>
9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Dont Know</u>	13b. MOTHER'S MAIDEN NAME <u>Dont Know</u>	14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME - ADDRESS <u>Bessie Harrison Winston 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture Surgical Neck of Left Femur</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>8 40 30</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Galathea Daviess MO</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>3-17-49 1:00A</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall</u> <u>31</u>	
22. I hereby certify that I attended the deceased from <u>Mar 18, 1949</u> , to <u>Mar 22, 1949</u> , that I last saw the deceased alive on <u>Mar 21, 1949</u> and that death occurred at <u>7 P m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Clayton E. Nelson M.D.</u>		23b. ADDRESS <u>Galathea MO</u>	23c. DATE SIGNED <u>3-23-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>24 March 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Winston Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Winston MO</u>
DATE REC'D BY LOCAL REG. <u>25 March 1949</u>	REGISTRAR'S SIGNATURE <u>Virginia M. Englehart</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kate Shoup Winston mo</u>	

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

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 L. O. Richman

Signed.....
Student Embalmer

Licensed Embalmer No. 3302

P. O. Address Fallston, Md.

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.