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FILED APR 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11371

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 108

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admittal.) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville	
c. LENGTH OF STAY (In this place) 40 yrs.		d. STREET ADDRESS (If rural, give location) 913 East Line St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION K.C.O.S. Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) ROSE b. (Middle) CAUDRON c. (Last) ENOCHS			4. DATE OF DEATH (Month) (Day) (Year) March 26, 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 18, 1887	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 0 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (State or foreign country) Coal City, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Henry Caudron	13b. MOTHER'S MAIDEN NAME Celine Carpenter	14. NAME OF HUSBAND XXXXXXXX George Enochs
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Henry Enochs	ADDRESS 913 E. Line, Kirksville, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		
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 none
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.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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?

22. I hereby certify that I attended the deceased from **Mar 25, 1949**, to **Mar 26, 1949**, that I last saw the deceased alive on **Mar 26, 1949**, and that death occurred at **8:00 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. O. Enochs	23b. ADDRESS Kirksville Mo	23c. DATE SIGNED 3-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-28-49	24c. NAME OF CEMETERY OR CREMATORY Maple Hills Cemetery	24d. LOCATION (City, town, or county) (State) Kirksville, Mo.
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DATE REC'D BY LOCAL REG. 4-21-49	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Pauline Howard	ADDRESS Kirksville, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 29 1949

RECEIVED

District Health Officer No.

District File Number 4-49-70

Date Filed APR 23 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 Clarence M. Billo

Licensed Embalmer No. 4375

P. O. Address Kisbville, 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.