No. 300
10.48

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11377

State File No.

BIRTH NO. REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 120

1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kirksville
c. LENGTH OF STAY (In this place): 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Nursing Home #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Adair
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Novinger
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Washington
c. (Last): Inbody

4. DATE OF DEATH (Month) (Day) (Year): April 21 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 2, 1870
9. AGE (In years last birthday): 79 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Adair County, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Noah Inbody
13b. MOTHER'S MAIDEN NAME: Lucindia Hargraves
14. NAME OF HUSBAND OR WIFE: Eliza Ann McKim

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Mrs. May Fountain; Novinger, Mo.

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) Medullary failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Congestive heart failure — 2 weeks
DUE TO (c) Arteriosclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* 4200

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-25, 1949, *to* 4-21, 1949, *that I last saw the deceased alive on* April 21, 1949, *and that death occurred at* 4:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Herman A. Mills D.O.
23b. ADDRESS: Kirksville - Mo
23c. DATE SIGNED: 4-21-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4/24/49
24c. NAME OF CEMETERY OR CREMATORY: New Harmony
24d. LOCATION (City, town, or county) (State): Schuyler Co., Missouri

DATE REC'D BY LOCAL REG.: 4-21-49
REGISTRAR'S SIGNATURE: Kate Lambert
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Paul M. Riley, Kirksville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY
c. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First)
b. (Middle)
c. (Last)
4. DATE OF DEATH (Month) (Day) (Year)

5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years) Last birthday
10. If under 1 year: Months, Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME
ADDRESS

RECEIVED
District Health Office No. 1
District File No. 64
Date Filed APR 26 1949

MEDICAL CERTIFICATION

18. DATE OF DEATH (Month, day, and year)
I attended the deceased from ..... to ..... I last saw the deceased alive on ..... The cause of death was as stated below.

19. CAUSE OF DEATH
Enter only one cause on each line.
(a) ..... (Disease or condition resulting in death)
(b) ..... (Antecedent causes)
(c) ..... (Underlying cause last)
The mode of dying, such as coma, shock, hemorrhage, etc. If trauma, the date, place, injury, or complication which caused death.

I. DISEASE OR CONDITION LEADING TO DEATH* (a)
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

20. DATE OF OPERATION
21. MAJOR FINDINGS OF OPERATION
22. AUTOPSY? YES ☐ NO ☐

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 ..... Student Embalmer

23a. ACCIDENT SUICIDE HOMICIDE (Specify)
23b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
23c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
24a. TIME OF INJURY (Month) (Day) (Year) (Hour)
24b. INJURY OCCURRED WHILE AT WORK ☐ YES ☐ NO
24c. HOW DID INJURY OCCUR?

Signed Roy H. Pierce
Licensed Embalmer No. 4432
P. O. Address Kirksville Mo.

25. I hereby certify that I last saw the deceased alive on ..... 19..., and that death occurred at ..... m., from the causes and on the date stated above.
26. SIGNATURE
(Degree or title)
26a. ADDRESS
26b. DATE SIGNED

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.

27a. BURIAL, CREMATION, REMOVAL (Specify)
27b. DATE
27c. NAME OF CEMETERY OR CREMATORY

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
28. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

WHITE—DIVISION OF HEALTH
GREEN—DEPARTMENT OF PUBLIC HEALTH
PINK—LOCAL REGISTRAR