

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1949

State File No. 16286

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 96

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carthage 11 2 weeks		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stotts City, Rural 35	
d. FULL NAME OF HOSPITAL OR INSTITUTION McCune Brooks		d. STREET ADDRESS (If rural, give location) 1/2 mile n. of Stotts City	

3. NAME OF DECEASED (Type or Print) John Wesley Daniel	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Feb 23 1949
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 20, 1886	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Battery manufacturer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Joseph Mo	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME John Wesley Daniel	13b. MOTHER'S MAIDEN NAME Campbell	14. NAME OF HUSBAND OR WIFE Metta
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Metta A. Daniel	ADDRESS Stotts City Mo
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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
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) nephritis, myocardial weakness; arteriosclerosis DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		592X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 29, 1949 to 2-23, 1949, that I last saw the deceased alive on 2-23, 1949, and that death occurred at 2-23 m., from the causes and on the date stated above.

23a. SIGNATURE W Russell Smith M.D.	(Degree or title)	23b. ADDRESS Carthage Mo	23c. DATE SIGNED 2-25-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-27-1949	24c. NAME OF CEMETERY OR CREMATORY Park Cemetery	24d. LOCATION (City, town, or county) (State) Carthage Mo
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DATE REC'D BY LOCAL REG 5-18-1949	REGISTRAR'S SIGNATURE L. B. Clinton M.D.	13025 FEDERAL DIRECTOR'S SIGNATURE Max L. Fessett	ADDRESS
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Per. n. Feryued (Licensed Embalmer's Statement on Reverse Side)

AUG 22 1949

DEC 21 1949

AUG 18 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 Max L. Jassett

Licensed Embalmer No. 4252

P. O. Address Midwestern, W

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.