S, No. 300-
v. 10.48

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19348

BIRTH NO. _____ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 6536 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY: Holt
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oregon-Rural
c. LENGTH OF STAY (in this place): 1/2 Day
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: Missouri
b. COUNTY: Holt
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oregon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Carl
b. (Middle): Esmond
c. (Last): McDonald

4. DATE OF DEATH (Month) June (Day) 8 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 9 1898
9. AGE (In years last birthday): 50
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): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oregon, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Amos McDonald
13b. MOTHER'S MAIDEN NAME: Carrie Barewalt
14. NAME OF HUSBAND OR WIFE:

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: Mrs. C.E. Reed
ADDRESS: Oregon, Missouri

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) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

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.

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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) Oregon (COUNTY) Holt (STATE) Mo
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* June 8, 1949, *to* June 8, 1949, *that I last saw the deceased alive on* June 8, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. F. Kramer MD
23b. ADDRESS: Oregon Mo
23c. DATE SIGNED: 6-9-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 11, 1949
24c. NAME OF CEMETERY OR CREMATORY: Maple Grove
24d. LOCATION (City, town, or county) (State): Oregon, Missouri

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: 122
25. FUNERAL DIRECTOR'S SIGNATURE: James H. Pettijohn
ADDRESS: Oregon Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 James H. Pettijohn

Licensed Embalmer No. 3192

P. O. Address Oregon 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.