

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **20581**

**FILED JUL 11 1949**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **290** PRIMARY REG. DIST. NO. **4428** Registrar's No. **87**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PULASKI</b> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richland</b> c. LENGTH OF STAY (in this place) <b>life</b> d. FULL NAME OF HOSPITAL OR INSTITUTION _____			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>PULASKI</b> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Richland</b> d. STREET ADDRESS (If rural, give location) _____		
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<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Jacob</b> b. (Middle) <b>Ryman</b> c. (Last) <b>Speeley</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>July 1 1949</b>			
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>married</b>	<b>8. DATE OF BIRTH</b> <b>May 27, 1864</b>	<b>9. AGE</b> (If years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>10</b>	IF UNDER 24 HRS. Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Mo</b>		<b>11. BIRTH PLACE</b> (State or foreign country) <b>Mo</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>

<b>13a. FATHER'S NAME</b> <b>John Jacob Speeley</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>?</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Julia Ann</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> _____	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Howard Speeley</b> <b>ADDRESS</b> <b>Richland</b>

<b>18. CAUSE OF DEATH</b> 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.		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 hrs.</b>
<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pneumonia + Myocarditis</b>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cold</b> DUE TO (c) _____		<b>4772</b>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Cardio-vascular disease</b>		<b>4772</b>

<b>19a. DATE OF OPERATION</b> _____	<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> _____

**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 11:30 a.m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>Lewis J. Myers D.O.</b>	<b>23b. ADDRESS</b> <b>Richland Mo</b>	<b>23c. DATE SIGNED</b> _____
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>July 3, 1949</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn</b>
<b>23d. LOCATION</b> (City, town, or county) (State) <b>Richland Pulaski Mo.</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wigil</b> <b>ADDRESS</b> <b>Stoutland, Mo.</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>7-7-49</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Thelma Buckthorn</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wigil</b> <b>ADDRESS</b> <b>Stoutland, Mo.</b>

JUL 7 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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, N.H.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.