

FILED JUN 28 1949

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

State File No. 22221

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 124

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

1. PLACE OF DEATH a. COUNTY <u>Saline County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Corder</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>Marshall Missouri</u>	
3. NAME OF DECEASED a. (First) <u>William</u> b. (Middle) <u>Marvin</u> c. (Last) <u>Kidd</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 22, 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 8, 1877</u>
9. AGE (In years last birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS* OR INDUSTRY <u>Same.</u>	12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13a. FATHER'S NAME <u>James Andrew Kidd</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Elizabeth Canada</u>	
14. NAME OF HUSBAND OR WIFE <u>Mary Alma Kidd</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE, OR NAME ADDRESS <u>Letha Kidd Heidbrink Walnut 4016</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition, Anemia</u> 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.		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 <u>6-17</u> , 19 <u>49</u> , to <u>June 22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>June 22</u> , 19 <u>49</u> , and that death occurred at <u>9-50</u> p.m. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>D. T. Coker M.D.</u>		23b. ADDRESS <u>Marshall, Mo.</u>	
23c. DATE SIGNED <u>22 June 1949</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>June 24, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Corder, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Adelbert H. ...</u>	
DATE REC'D BY LOCAL REG. <u>June 23-1949</u>		REGISTRAR'S SIGNATURE <u>Edw. J. Gray</u>	

RECEIVED JUN 27

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-27-49

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 Robert H. Taylor

Licensed Embalmer No. 539

P. O. Address Highamsville

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.