

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22815

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

BIRTH NO.		REG. DIST. NO. 59	PRIMARY REG. DIST. NO. 4097	Registrar's No. 112
1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Ill b. COUNTY St. Clair		
b. CITY (If outside corporate limits, write RURAL and give township) Harrisonville		c. LENGTH OF STAY (in this place) 14 days d. CITY (If outside corporate limits, write RURAL and give township) St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Leslie Trailer Camp		d. STREET ADDRESS (If rural, give location) 517 So. 6th St.		
3. NAME OF DECEASED (Type or Print) a. (First) (PANSI) b. (Middle) Thelma c. (Last) METCALF		4. DATE OF DEATH (Month) (Day) (Year) July 29-1949		
5. SEX Fe	6. COLOR OR RACE Wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 3-1910	
9. AGE (In years last birthday) 39		10. MONTHS 1		11. DAYS 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Chas. Blakely		
13b. MOTHER'S MAIDEN NAME Barnes		14. NAME OF HUSBAND OR OTHER PERSON WITH WHOM DECEASED LIVED AT TIME OF DEATH Earl Metcalf		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Earl Metcalf
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) SHOCK ELECTRICAL		17. ADDRESS E. St. Louis Mo		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		1 61140		
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.		✓ 22		
19a. DATE OF OPERATION ✓		19b. MAJOR FINDINGS OF OPERATION ✓		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) HARRISONVILLE CASS MO
21d. TIME OF INJURY July 29-1949 3:30 P.M.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Lightning STRUCK Light cord connected to lamp in hand
22. I hereby certify that I attended the deceased from ✓ , 19 49 , to ✓ , 19 49 , that I last saw the deceased alive on 19 , and that death occurred at 3:30 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE J. J. Dargatzis		23b. ADDRESS Harrisonville Mo		23c. DATE SIGNED July 29, 49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 1-49		24c. NAME OF CEMETERY OR CREMATORY Mount Hope
24d. LOCATION (City, town, or county) (State) E. St. Louis Ill.		DATE REC'D BY LOCAL REG. July 30, 1949		
REGISTRAR'S SIGNATURE Laura J. Jones		51		24e. HEALTH DEPARTMENT DIRECTOR'S SIGNATURE W. H. ...
ADDRESS Harrisonville Mo		ADDRESS Harrisonville 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

Floyd Atkinson

Licensed Embalmer No.

3920

P. O. Address

Harrisonville

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.

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