

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 26 1949

No. 300
10.48
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BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 54

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|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>SAFAYETTE</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SAFAYETTE</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LEXINGTON</u> | | c. LENGTH OF STAY (in this place) <u>1</u> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LEXINGTON</u> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>34 1/2 MAIN</u> | | | d. STREET ADDRESS (If rural, give location) <u>34 1/2 MAIN</u> | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Wm</u> | | b. (Middle) <u>H. H.</u> | | c. (Last) <u>KEY</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>6/27/49</u> | |
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| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | | 8. DATE OF BIRTH <u>8/4/1862</u> | | 9. AGE (In years) (Months) (Days) (Hours) (Min.) <u>86 10 23</u> | |
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| 10a. USUAL OCCUPATION (Give kind of work done during present working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>CARROLL Co. Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
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| 13a. FATHER'S NAME <u>JONATHAN KEY</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARGARET CASSKY</u> | | 14. NAME OF HUSBAND OR WIFE <u>X</u> | |
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| 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. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>CHARLES KEY LEX., MO</u> | |
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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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Cardio-vascular disease</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbidity 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. | | | | <u>442A</u> | |

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| 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 checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
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22. I hereby certify that I attended the deceased from Feb. 28, 1949 to June 25, 1949, that I last saw the deceased alive on June 25, 1949, and that death occurred at 12 P. m. from the causes and on the date stated above.

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|--|--|------------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>Bill Wardner</u> | | 23b. ADDRESS <u>Lexington, Mo.</u> | | 23c. DATE SIGNED <u>6/28/49</u> | |
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| 24a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>6/29/49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>DOYER CEM.</u> | | 24d. LOCATION (City, town, or county) (State) <u>DOYER, MO</u> | |
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| DATE REC'D BY LOCAL REG. <u>9/2/49</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 156 5. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>FORREST F. TEMPEL LEX., MO</u> | |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Jul 23
District File Number _____
Date Filed 7-23-49

W 019

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 [Signature]

Licensed Embalmer No. 2983

P. O. Address Leemington, 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.