

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26278**

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **376**

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Callaway	
b. CITY (If outside corporate limits, write RURAL and give township) Fulton, Mo		c. CITY (If outside corporate limits, write RURAL and give township) Fulton	
c. LENGTH OF STAY (in this place) 26 days		d. STREET ADDRESS (If rural, give location) P. O. # 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No 1			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JOHN	b. (Middle) S	c. (Last) HELM	(Month) Aug	(Day) 14	(Year) 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug 31, 1868	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 11	IF UNDER 12 HRS. Days 13	IF UNDER 1 MIN. Hours 3
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Block Print	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.B
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13a. FATHER'S NAME Wm Helm	13b. MOTHER'S MAIDEN NAME Millman	14. NAME OF HUSBAND OR WIFE unk
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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) unk	16. SOCIAL SECURITY NO. unk	17. INFORMANT'S SIGNATURE OR NAME State Hospital No 1	ADDRESS Fulton, Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 12 21
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	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. Gen. Arterio Sclerosis, Hypo. Pneumonia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **19 July**, 1949, to **14 Aug**, 1949, that I last saw the deceased alive on **13 Aug**, 1949, and that death occurred at **3:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE G.S. Warack	(Degree or title) M.D. U	23b. ADDRESS Fulton, Mo	23c. DATE SIGNED 14 Aug 49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Aug-16-1949	24c. NAME OF CEMETERY OR CREMATORY New Florence Cem.	24d. LOCATION (City, town, or county) (State) New Florence Mo
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DATE REC'D BY LOCAL REG. Aug-14-1949	REGISTRAR'S SIGNATURE Maritta Lawrence	426	25. FUNERAL DIRECTOR'S SIGNATURE Wallace Funeral Home	ADDRESS Fulton, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

District File Number _____
District Health Officer No. 9,
RECEIVED AUG 25 1919

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 Wenzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton, 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.