

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27397

FILED SEP 12 1949

State File No. ....

BIRTH NO. 50378-49 REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 3041 Registrar's No. 95

61  
3  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Macon</u>	c. LENGTH OF STAY (In this place) township) <u>16 hrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Callao Rural</u>	<u>0</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SMARITAN</u>		d. STREET ADDRESS (If rural, give location) <u>Callao Imp. R.F.D.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>RICHARD</u> b. (Middle) <u>Lee</u> c. (Last) <u>ISAACSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-28-1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>8-22-49</u>
9. AGE (In years last birthday) <u>16</u> IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> IF UNDER 24 HRS. Hour <u>16</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Macon Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>VERN ISAACSON</u>	
13b. MOTHER'S MAIDEN NAME <u>Ruth Shoemaker</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)* (If yes, give war or dates of service) <u>Mo</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>None Isaacson</u>		ADDRESS <u>Callao Mo</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary atelectasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Myocardial Infarction</u> <u>12 hrs</u> DUE TO (c) <u>Emphysema</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u> <u>7620</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Callao (Macon) Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR <u>None</u>		22. I hereby certify that I attended the deceased from <u>8-22, 1949</u> to <u>8-23, 1949</u> that I last saw the deceased alive on <u>8-23, 1949</u> and that death occurred at <u>8:30</u> m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>[Signature]</u>		23b. ADDRESS <u>Macon Mo</u>	
23c. DATE SIGNED <u>9-3-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>8/29/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove</u>	
24d. LOCATION (City, town, or county) (State) <u>Callao Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	
DATE REC'D BY LOCAL REG. <u>9-3-49</u>		REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Callao Mo</u>	

RECEIVED SEP 7 1949  
District Health Officer No. 1  
District File Number 9-49-15  
Date Filed SEP 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 H. S. Edwards.....

Licensed Embalmer No. 1961

P. O. Address Bowie Md

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.