

FILED OCT 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29571

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>55</u>		PRIMARY REG. DIST. NO. <u>3011</u>		Registrar's No. <u>88</u>	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Carrollton</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Hale</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SALES HOSP-D</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (First) <u>Coxe</u>		b. (Middle) <u>Deer</u>		c. (Last) <u>Deardorff</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept-10-1949</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug-22-1874</u>	
9. AGE (In years) (If under 1 year, last birthday) <u>75</u>		10. MONTHS <u>0</u>		10. DAYS <u>18</u>		10. HOURS <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bethsill Mo</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>John Goltz</u>		13b. MOTHER'S MAIDEN NAME <u>Julie Lightfoot</u>		14. NAME OF HUSBAND OR WIFE <u>James Deardorff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ralph Stearns Hale 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Heart failure</u> ANCECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Starvation</u> DUE TO (c) <u>Carcinoma metastatic</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>March 49</u> <u>Sept 49</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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) (Min)		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>Aug</u> , 1949, to <u>10 Sept</u> , 1949 that I last saw the deceased alive on <u>10 Sept</u> , 1949 and that death occurred at <u>12:01 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Erroll Warren Allen MD</u>				23b. ADDRESS <u>Tina Mo.</u>		23c. DATE SIGNED <u>10 Sept 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>9/12/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hale Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hale Mo</u>	
DATE REC'D BY LOCAL REG. <u>9/12/49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Herbert Calvert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank E. Stearns</u>		ADDRESS <u>Hale Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 19

District Health Officer No. 8,

District File Number _____

Date Filed 1-30-49

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.

Signed

Shank E. Slater

Signed _____

Student Embalmer

Licensed Embalmer No. 937

P. O. Address Hale Ind

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.