No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 20 1949

State File No. 30912

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 5644 Registrar's No. 65

1. PLACE OF DEATH
a. COUNTY: LAFAYETTE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEXINGTON
c. LENGTH OF STAY (in this place): 1 WK.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: LAFAYETTE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): DOVER
d. STREET ADDRESS (If rural, give location): 5-D

3. NAME OF DECEASED (Type or Print)
a. (First): EMMA
b. (Middle): L.
c. (Last): MIERS

4. DATE OF DEATH (Month) (Day) (Year): AUG 29 1949

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: JAN. 8 1872
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 7 Days 21 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DOVER, MO
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: ELIAS MIERS
13b. MOTHER'S MAIDEN NAME: SALLIE LOVELADY
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: MRS LESTER CONNER — ADDRESS: LEX. MO

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): Cardiac Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Thrombosis
DUE TO (c): Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4201

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1949, *to* Aug 29, 1949, *that I last saw the deceased alive on* Aug 29, 1949, *and that death occurred at* 12 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Lexington Mo
23c. DATE SIGNED: 8/29/49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: AUG. 31, 1949
24c. NAME OF CEMETERY OR CREMATORY: DOVER
24d. LOCATION (City, town, or county) (State): DOVER MO.

DATE REC'D BY LOCAL REG.: 8 Sept 49
REGISTRAR'S SIGNATURE: Minerva E. Eachbrook 156
25. FUNERAL DIRECTOR'S SIGNATURE: FORREST F. TEMPEL — ADDRESS: LEX. MO

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 12
District Health Officer No. 8,
District File Number
Date Filed 9-17-49

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 Geo. McKean

Signed .....
Student Embalmer

Licensed Embalmer No. 2983

P. O. Address Lexington 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.