

FILED OCT 14 1949

STANDARD CERTIFICATE OF DEATH

State File No. 31033

BIRTH NO.		REG. DIST. NO. 207		PRIMARY REG. DIST. NO. 4319		Registrar's No. 29	
1. PLACE OF DEATH a. COUNTY Maries				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Maries			
b. CITY (If outside corporate limits, write RURAL and give township) Belle		c. LENGTH OF STAY (in this place) 26-yr		c. CITY (If outside corporate limits, write RURAL and give township) Belle			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) Merritt		a. (First)		b. (Middle) E.		c. (Last) Decker	
4. DATE OF DEATH (Month) (Day) (Year) Sept 29 -1949		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH May 18-1880		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS/OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Welcomb Decker		13b. MOTHER'S MAIDEN NAME Mary Lowe		14. NAME OF HUSBAND OR WIFE Josie Loyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 494-09-3839		17. INFORMANT'S SIGNATURE OR NAME Mrs. Josie Decker		ADDRESS Belle	
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) Myocardial Regeneration ANTECEDENT CAUSES Chronic Nephritis 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.				INTERVAL BETWEEN ONSET AND DEATH 4 yrs 3 yrs 5 1/2 y	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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)		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 4/2, 1948 , to 9/29, 1949 , that I last saw the deceased alive on 9/27, 1949 , and that death occurred at 2:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) R. H. Schoenbach, M.D.				23b. ADDRESS Belle, Mo.		23c. DATE SIGNED 9/30/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-1-49		24c. NAME OF CEMETERY OR CREMATORY Liberty		24d. LOCATION (City, town, or county) (State) Maries County - Mo.	
DATE REC'D BY LOCAL REG. Oct 7-1949		REGISTRAR'S SIGNATURE Kathleen Howard		25. FUNERAL DIRECTOR'S SIGNATURE Christa Sasser		ADDRESS Sassmann's Funeral Service - Belle	

(Licensed Embalmer's Statement on Reverse Side)

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

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District File Number _____
District Health Officer No. 9,
RECEIVED
OCT 11 1919

AUG 13 1951

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 Chester Sessum

Signed _____
Student Embalmer

Licensed Embalmer No. 4178

P. O. Address Bland

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.