

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31389

State File No. \_\_\_\_\_

FILED SEP 22 1949

BIRTH NO. _____		REG. DIST. NO. <u>280</u>		PRIMARY REG. DIST. NO. <u>4423</u>		Registrar's No. <u>68</u>	
1. PLACE OF DEATH a. COUNTY <u>Platte</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Weston</u>		c. LENGTH OF STAY (In this place) <u>Weston</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Weston</u>		d. STREET ADDRESS (If rural, give location) <u>Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>mpone</u>				d. STREET ADDRESS (If rural, give location) <u>Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alma</u>		b. (Middle) <u>Elizabeth</u>		c. (Last) <u>Dydell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8-28-49</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>10-28-1915</u>	
9. AGE (In years last birthday) <u>33</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 MTH. Hours _____ Mins. _____		11. BIRTHPLACE (State or foreign country) <u>Platte City, Missouri</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 <u>home</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William E. Sanders</u>			13b. MOTHER'S MAIDEN NAME <u>Ola Boone</u>			14. NAME OF HUSBAND OR WIFE <u>Frazier Dydell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frazier Dydell Weston, 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>Coronary occlusion? possibly fatty degeneration of heart? Rupture of heart?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.</u>						DUE TO (b) <u>Extreme obesity</u> <u>12 yrs.</u>	
DUE TO (c) <u>Edema of lungs, extreme dyspnea</u>						Patient seen 15 minutes before death.	
II. OTHER SIGNIFICANT CONDITIONS* <u>Was aroused from sleep from difficult breathing, died shortly after.</u>						Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		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>XXXX</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>XXXX</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>XXXX</u> <u>4201</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>XXXX.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>XXXX</u>			
22. I hereby certify that I attended the deceased from <u>Aug 28, 1949</u> , to <u>Aug 28, 1949</u> , that I last saw the deceased alive on <u>Aug 28, 1949</u> , and that death occurred at <u>2 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Lewis C. Calvert M.D.</u>				23b. ADDRESS <u>Weston Missouri</u>		23c. DATE SIGNED <u>8/31/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-31-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Platte City Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Platte City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-31-49</u>		REGISTRAR'S SIGNATURE <u>Alpha Racine</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>257 Vaughn Funeral Home Weston Mo.</u>		ADDRESS	

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED SEP 8  
District Health Officer No. 8,

District File Number.....

Date Filed 9-21-49

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed

*W. R. Vaughn*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4023

P. O. Address Weston, 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.