

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33627**

FILED NOV 10 1949

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **945**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) Rural—South Campbell Twp		c. CITY (If outside corporate limits, write RURAL and give township) Ash Grove	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) R. R. 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION OSARK OSTEOPATHIC HOSPITAL		4. DATE OF DEATH (Month) (Day) (Year) 10-27-49	
3. NAME OF DECEASED (Type or Print) DELLA	a. (First)	b. (Middle)	c. (Last) DANIELS
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 8-24-1866
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months 2 Days 3	IF UNDER 1 Hrs. Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Granger Co. Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Wm. D. Burchett	13b. MOTHER'S MAIDEN NAME Alda B. Bridgewater	14. NAME OF HUSBAND OR WIFE Comer Daniels Adkins	
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. None	17. INFORMANT'S SIGNATURE OR NAME Comer Daniels Adkins	
18. CAUSE OF DEATH—Enter only one cause per line for (a), (b), and (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 794X	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES	
II. OTHER SIGNIFICANT CONDITIONS		DUE TO (b)	
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) (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 9-29 , 1949, to 10-27 , 1949, that I last saw the deceased alive on 10-27 , 1949, and that death occurred at 11:35 Am. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Della Daniels		23b. ADDRESS 202 Springfield Mo	
23c. DATE SIGNED 10/27/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 10-29-49		24c. NAME OF CEMETERY OR CREMATORY Johns Chapel	
24d. LOCATION (City, town, or county) (State) South of Ash Grove Mo.		25. FUNERAL DIRECTOR'S SIGNATURE W.S. Daudley	
25. ADDRESS Union Adkins		DATE REC'D BY LOCAL REG. 11-4-49	

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

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 Paul V. Gandy

Licensed Embalmer No. 7719

P. O. Address Cash Grove 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.