

FILED OCT 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33672**

BIRTH NO. _____		REG. DIST. NO. <b>137</b>		PRIMARY REG. DIST. NO. <b>3023</b>		Registrar's No. <b>281</b>	
1. PLACE OF DEATH a. COUNTY <b>HONORAY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>HICKORY</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CLINTON 0</b>		c. LENGTH OF STAY (In this place) <b>1 month</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>WHEATLAND 0</b>		43	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Watzal Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>0</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ARVILA</b>		b. (Middle) <b>DOLL</b>		c. (Last) <b>NIBLACK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 17 - 1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>FEB. 20, 1915</b>	
9. AGE (In years last birthday) <b>74</b>		10. MONTHS <b>7</b>		11. DAYS <b>27</b>		12. HOURS <b>3</b> MIN. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>Joseph McCracken</b>			13b. MOTHER'S MAIDEN NAME <b>CRUTSINGER</b>			14. NAME OF HUSBAND OR WIFE <b>John Henry Niblack</b>	
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. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Odessa Goodman</b>			
17. ADDRESS							
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) <b>Circulatory Failure</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>							
ANTECEDENT CAUSES							
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
DUE TO (b) <b>acute Coronary Thrombosis</b> <b>1 wk</b>							
DUE TO (c) <b>Diabetes Mellitus + arteriosclerosis</b> <b>10 yrs.</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>2.0X</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, 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 <b>9-17</b> , 19 <b>49</b> , to <b>10-16</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>10/16</b> , 19 <b>49</b> , and that death occurred at <b>5:55 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>R. J. Powell</b>				23b. ADDRESS <b>Clinton Mo.</b>		23c. DATE SIGNED <b>10/17/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Oct 20 - 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CRUTSINGER</b>		24d. LOCATION (City, town, or county) (State) <b>HICKORY CO. MO.</b>	
DATE REC'D BY LOCAL REG. <b>Oct - 20 - 49</b>		REGISTRAR'S SIGNATURE <b>Florence Adair</b>		FUNERAL DIRECTOR'S SIGNATURE <b>William C. Mendenhall</b>		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side) **Hathaway**

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

RECEIVED

District Health Officer No.

District File Number 9-49-

Date Filed 11-24-49

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.

Student \_\_\_\_\_  
Student Embalmer

Signed William C. Mendenhall

Licensed Embalmer No. 4449

P. O. Address Urbana 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.