

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34265

State File No. _____

FILED NOV 10 1949

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) Lexington		b. COUNTY Lafayette	
c. LENGTH OF STAY (In this place) year		c. CITY (If outside corporate limits, write RURAL and give township) Lexington	
d. FULL NAME OF HOSPITAL OR INSTITUTION N. 10th St.		d. STREET ADDRESS (If rural, give location) N. 10th St.	

3. NAME OF DECEASED (Type or Print) a. (First) Henry	b. (Middle) Joseph	c. (Last) Utt	4. DATE OF DEATH (Month) (Day) (Year) Oct. 9, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 26, 1865	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 13	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lexington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry J. Utt	13b. MOTHER'S MAIDEN NAME Martha J. Slusher	14. NAME OF HUSBAND OR WIFE X
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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. 0	17. INFORMANT'S SIGNATURE OR NAME A.L. Utt	ADDRESS Lexington, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 15 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Night Blindness DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3 31X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Sept 25, 1949, to Oct. 9, 1949 that I last saw the deceased alive on Oct. 8th, 1949, and that death occurred 8:30 A.M. from the causes and on the date stated above.

23a. SIGNATURE A. Wright	(Degree or title)	23b. ADDRESS Lexington, Mo.	23c. DATE SIGNED 10/10/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 10, 1949	24c. NAME OF CEMETERY OR CREMATORY Maahpelah	24d. LOCATION (City, town, or county) (State) Lexington, Mo.
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DATE REC'D BY LOCAL REG. Oct 30/49	REGISTRAR'S SIGNATURE Wm. E. ...	FUNERAL DIRECTOR'S SIGNATURE 156 1/2 ...	ADDRESS Lex. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8, 7

Wright

District File Number _____

Date Filed 11-9-49

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

J. M. Kean

Licensed Embalmer No. 2983

P. O. Address Leungton, N.W.

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.