

FILED NOV 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **34449**BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 4328 Registrar's No. 96

| | | | | | |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Mississippi | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri | | b. COUNTY Mississippi | |
| b. CITY (If outside corporate limits, write RURAL and give township) Bertrand | | c. LENGTH OF STAY (in this place) 9 years | | c. CITY (If outside corporate limits, write RURAL and give township) Bertrand | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION At Home | | d. STREET ADDRESS (If rural, give location) No Address Listed | | | |

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|--|--------------------------|--------------------------|---------------------------|---------------------|-----------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) AARON | b. (Middle) C. | c. (Last) DOAN | (Month) October | (Day) 29, | (Year) 1949 |

| | | | | | | | | |
|-----------------------|----------------------------------|--|--|--|---------------------------------------|--------------------------------------|------------------------------------|-----------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH February 15, 1880 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months 8 | IF UNDER 1 YEAR Days 14 | IF UNDER 1 HR. Hours | IF UNDER 1 HR. Min. |
|-----------------------|----------------------------------|--|--|--|---------------------------------------|--------------------------------------|------------------------------------|-----------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (State or foreign country) Dixon Springs, Texas Illinois | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| | | |
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| 13a. FATHER'S NAME Not Known | 13b. MOTHER'S MAIDEN NAME Not Known | 14. NAME OF HUSBAND OR WIFE Fleddie Doan |
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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) No. | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Mr. E. A. Doan, Cairo, Illinois | ADDRESS Cairo, Illinois |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic mellitus - coma | | 3 days |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetic mellitus DUE TO (c) | | 6-8 years |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 260X | |

| | | |
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| 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) |
|--|--|---|

| | | |
|--|--|----------------------------|
| 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? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from Oct 28, 1949, to Oct 28, 1949, that I last saw the deceased alive on Oct 28, 1949, and that death occurred at 6:50P m., from the causes and on the date stated above.

| | | | |
|--|-------------------|--------------------------------------|-------------------------------------|
| 23a. SIGNATURE William L. Davis M.D. | (Degree or title) | 23b. ADDRESS Charleston Mo | 23c. DATE SIGNED 11-10-49 |
|--|-------------------|--------------------------------------|-------------------------------------|

| | | | |
|--|-----------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Oct. 31, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Armer Cemetery | 24d. LOCATION (City, town, or county) (State) Bertrand (Rural) Missouri |
|--|-----------------------------------|---|---|

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|---|--|--|-----------------------------------|
| DATE REC'D BY LOCAL REG. Nov. 10-49 | REGISTRAR'S SIGNATURE Mr. John Bondurant | 25. FUNERAL DIRECTOR'S SIGNATURE Edward E. Ammer | ADDRESS Charleston, Mo. |
|---|--|--|-----------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 12 REC'D

RECEIVED

Miss. Co. Health Dept

County File No. _____

Date Filed NOV 14 194

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 Edward E. Mueller

Licensed Embalmer No. 4164

P. O. Address Charleston, W. Va.

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.