

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35783

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 1076 Registrar's No. 4148

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Wright</u>					
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>Richmond Heights</u> )		c. LENGTH OF STAY (in this place) <u>13</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Clarion</u>		d. STREET ADDRESS (If rural, give location) <u>*****</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>JOHNSTON.</u> c. (Last) <u>BIRDSALL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13, 1949</u>						
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8, 1894</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (State or foreign country) <u>Clarion, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Benj. Birdsall</u>			13b. MOTHER'S MAIDEN NAME <u>Isabelle Johnston</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel Birdsall</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ethel Birdsall</u> ADDRESS <u>Clarion, Iowa</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, asthenia, 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) <u>Gastric Ulcer</u>				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____					
DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. <u>Anuria</u>				540.1				540.1	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Perforating Ulcer of Stomach</u>				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 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 <u>10-7-49</u> to <u>10-13-49</u> , that I last saw the deceased alive on <u>10-13-49</u> , and that death occurred at <u>4 P.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>John W Stewart</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>4660 Maryland - St Louis</u>		23c. DATE SIGNED <u>10-14-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Oct. 14, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>*****</u>		24d. LOCATION (City, town, or county) (State) <u>Clarion, Iowa</u>			
DATE REC'D BY LOCAL REG. <u>OCT 14 1949</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Gombke</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander S. ...</u>		ADDRESS <u>6175 Pelmar Blvd</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. John W. Stewart.  
4660 Maryland Ave.  
Ros 5273  
Hrs.

NOT  
1948

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 Joseph E. McCullough

Licensed Embalmer No. 2460

P. O. Address 6170 Delaware

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.