

FILED NOV 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35971

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BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 200

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| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u> | | c. LENGTH OF STAY (in this place) <u>Life</u> | |
| c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u> | | d. STREET ADDRESS (If rural, give location) <u>South Conway</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Conway</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>NATHAN</u> | b. (Middle) <u>HUSTON</u> | c. (Last) <u>DECKER</u> |
| 4. DATE OF DEATH | (Month) <u>Oct.</u> | (Day) <u>24</u> | (Year) <u>1949</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb. 7, 1870</u> |
| 9. AGE (in years last birthday) <u>79</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 YEAR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Unknown</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Minnie H. Decker</u> | |
| 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. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Marion M. Decker</u> ADDRESS <u>Kansas City, Mo.</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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerotic Heart Disease</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. INTERVAL BETWEEN ONSET AND DEATH <u>1222</u> | |
| 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 bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____ | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 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>Oct 17, 1949</u> , to <u>Oct 24, 1949</u> , that I last saw the deceased alive on <u>Oct 21, 1949</u> , and that death occurred at <u>12 P.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE <u>James A. Reed</u> (Degree or title) <u>M.D.</u> | | 23b. ADDRESS <u>Marshall, Mo.</u> | 23c. DATE SIGNED <u>10-25-49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Oct. 26, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>5 Mi. E. Marshall, Mo.</u> |
| DATE REC'D BY LOCAL REG. <u>Oct 25-1949</u> | REGISTRAR'S SIGNATURE <u>Sidney T. Gray</u> 385 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Hershberger</u> ADDRESS <u>Marshall, Mo.</u> | |

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

RECEIVED OCT 31

District Health Officer No. 8,

District File Number.....

Date Filed 11-3-49

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 Joseph P. Mackler

Licensed Embalmer No. 4571

P. O. Address Marshall, 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.