

FILED OCT 26 1949

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

35973

State File No. ....

BIRTH NO. _____		REG. DIST. NO. 324		PRIMARY REG. DIST. NO. 3072		Registrar's No. 198	
1. PLACE OF DEATH a. COUNTY <b>Saline</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall, Mo.</b>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fitzgibbons Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>457 West Marion</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b>			b. (Middle) <b>Henry</b>			c. (Last) <b>Latham</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 17 1949</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>Feb. 11-1865</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>6</b>	IF UNDER 2 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Gilliam-Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Samuel Latham</b>			13b. MOTHER'S MAIDEN NAME <b>Tracy Wilkes</b>			14. NAME OF HUSBAND OR WIFE <b>-----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>-</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Russell Hoyes-Marshall, Mo.</b>		ADDRESS. <b>-----</b>	
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>Bacteremia - meningitis</b>  ANTECEDENT CAUSES Morbidity 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. <b>Chronic nephritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Oct. 9, 1949</b>  <b>5:11</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) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Marshall Saline Mo</b>			
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 <b>Oct. 14, 1949</b> , to <b>Oct. 17, 1949</b> , that I last saw the deceased alive on <b>Oct. 16, 1949</b> , and that death occurred at <b>6:20 a. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>J. L. L. M. D.</b>				23b. ADDRESS <b>Marshall, Mo.</b>		23c. DATE SIGNED <b>10-18-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10-19-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Gilliam Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Gilliam-Missouri</b>	
DATE REC'D BY LOCAL REG. <b>Oct. 18-1949</b>		REGISTRAR'S SIGNATURE <b>Edw. J. Gray</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. Leola Bursey Marshall, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 24  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 10-25-49

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. Fred Sweeney  
Licensed Embalmer No. 3235

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.