

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36160**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 3000		Registrar's No. 330	
1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Adair			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville 11		c. LENGTH OF STAY (In this place) 77 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		3 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION Community Nursing Home #1				d. STREET ADDRESS (If rural, give location) 610 S. 6th St.			
3. NAME OF DECEASED (Type or Print) a. (First) Daniel		b. (Middle) H.		c. (Last) DENNISON		4. DATE OF DEATH (Month) (Day) (Year) 11 - 7 - 49	
5. SEX MO Wh		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH 1-11-69	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME William Dennison		13b. MOTHER'S MAIDEN NAME Martha Jane Turner		14. NAME OF HUSBAND OR WIFE Flora E. Dennison	
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. _____		17. INFORMANT'S SIGNATURE OR NAME W. R. Dennison		ADDRESS Ethel Mo	
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) Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH -	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Coronary Sclerosis		unknown		unknown	
DUE TO (c) Generalized Arteriosclerosis		unknown		unknown		4201	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		-		-		-	
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) (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 8-23-1949 , to 11-7-1949 , that I last saw the deceased alive on 11-7-1949 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE M. T. Stutts (Degree or title) D.O.				23b. ADDRESS Kirksville, Mo		23c. DATE SIGNED 11-7-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov 9 1949		24c. NAME OF CEMETERY OR CREMATORY Helton		24d. LOCATION (City, town, or county) (State) North of Goldsberry Macon Mo	
DATE REC'D BY LOCAL REG. 11-14-49		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE M. H. McCallister		ADDRESS South Gifford Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 23 1949
District Health Officer No. 10
District File Number 11-49-295
Date Filed NOV 23 1949

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 W. H. G. Collins

Licensed Embalmer No. 2052

P. O. Address South Gifford No

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.