

FILED NOV 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36305**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 280

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

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. LENGTH OF STAY (In this place) <u>11 Days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Easley</u>		10
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Tyler's Convalescent Home</u>			d. STREET ADDRESS (If rural, give location) <u>0</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>EARL</u> b. (Middle) <u>J.</u> c. (Last) <u>GNEVO</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 4, 1949</u>		
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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>April 10, 1894</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
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13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>507-05-4723</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Joseph Lentz, So. Omaha, Nebraska</u>			
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Paralysis</u>			<u>8 days</u>	
	DUE TO (c) <u>Septicæmia</u>			<u>No date</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>334X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>21a</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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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?		
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22. I hereby certify that I attended the deceased from Nov 25, 1949 to Nov 4, 1949, that I last saw the deceased alive on Nov 4, 1949, and that death occurred at 11:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. B. Williamson M.D.</u>		23b. ADDRESS <u>Columbia, Mo.</u>		23c. DATE SIGNED <u>11-6-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 7, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>		
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DATE REC'D BY LOCAL REG. <u>Nov. 16 1949</u>	REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		31	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker Funeral Service, Columbia Mo</u>	
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RECEIVED 11-21-49  
District Health Officer No. 92  
District File Number

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. S. Pittsich*  
Licensed Embalmer No. *3893*  
P. O. Address *Calumet, 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.