

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36787**

BIRTH NO. **79464-49** REG. DIST. NO. **107** PRIMARY REG. DIST. NO. **3019** Registrar's No. **149**

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

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Dunklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Summit		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Summit Mo.	
c. LENGTH OF STAY (in this place) 3 wks		4. STREET ADDRESS (If rural, give location) Gen. Del.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Presnell Hospital			

3. NAME OF DECEASED (Type or Print) PAGEANA CLAUDEN MOEN			4. DATE OF DEATH (Month) (Day) (Year) Nov 22, 1949		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 10-31-49		9. AGE (In years last birthday) 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Summit Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Claude Moen		13b. MOTHER'S MAIDEN NAME Leola Wammack		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Claude Moen ADDRESS Summit Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Starvation		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Starvation		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Preaturity			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		776X	

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) m.		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 **10-31, 1949**, to **11-22, 1949**, that I last saw the deceased alive on **11-22, 1949**, and that death occurred at **9:50 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H.C. Wilson MD		23b. ADDRESS Kennett, Mo.		23c. DATE SIGNED 11-26-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) 11/23/49		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Leola Cemetery	
24d. LOCATION (City, town, or county) (State) Summit, Mo		DATE REC'D BY LOCAL REG. 11-28-1949		REGISTRAR'S SIGNATURE Carl Hubbard	
25. FUNERAL DIRECTOR'S SIGNATURE McDaniel Funeral Service		ADDRESS Summit, Mo			

Res. Dunklin County Health Dep

12-6-49

County File No. 1249-9

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 4466

Signed
Student Embalmer

P. O. Address [Signature]

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.