

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36799

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 108 PRIMARY REG. DIST. NO. 2423 Registrar's No. 24

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dunklin</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Senath</u> OR TOWN <u>Senath</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Senath</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rural</u>   |  | d. STREET ADDRESS (If rural, give location) <u>Rural</u>  |  |
| 3. NAME OF DECEASED<br>a. (First) <u>ARVIL</u>   |  | b. (Middle) _____ c. (Last) <u>EARL</u>   |  |
| 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 26 1949</u>   |  | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>   |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>  |  | 8. DATE OF BIRTH <u>Oct 9, 1899</u>   |  |
| 9. AGE (In years last birthday) <u>49</u>  |  | IF UNDER 1 YEAR Months _____ Days _____   |  |
| IF UNDER 24 HRS. Hours _____ Min. _____  |  | 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 <u>FARM</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>MAYFIELD, KY 1</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  | 13a. FATHER'S NAME <u>Will EARL</u>   |  |
| 13b. MOTHER'S MAIDEN NAME <u>LULA</u>  |  | 14. NAME OF HUSBAND OR WIFE <u>MAYME EARL</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. _____   |  |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs MAYME EARL Senath</u>   |  | ADDRESS _____   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mycocarditis</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Gastritis</u><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>none discernable</u> |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>Don't know</u>   |  | 4222  |  |
| 19a. DATE OF OPERATION <u>None</u>   |  | 19b. MAJOR FINDINGS OF OPERATION <u>None</u>  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>  |  |
| 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u>None</u>  |  |
| 21f. HOW DID INJURY OCCUR? <u>None</u>   |  | 22. I hereby certify that I attended the deceased from <u>Aug 26, 1949</u> , to <u>Aug 26, 1949</u> , that I last saw the deceased alive on <u>Aug 26, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above.  |  |
| 23a. SIGNATURE <u>Robert W. Martin M.D.</u> (Degree or title)  |  | 23b. ADDRESS <u>Senath, Mo</u>  |  |
| 23c. DATE SIGNED <u>8-26-49</u>  |  | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |
| 24b. DATE <u>8/28/49</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Senath Cemetery</u>   |  |
| 24d. LOCATION (City, town, or county) (State) <u>Senath, Mo</u>  |  | DATE REC'D BY LOCAL REG. <u>11-12-1949</u>  |  |
| REGISTRAR'S SIGNATURE <u>Mrs J. H. Lamer</u>   |  | FUNERAL DIRECTOR'S SIGNATURE <u>A. Bradford Senath</u>  |  |
| ADDRESS _____  |  | ADDRESS _____   |  |

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

35  
0  
0

RECEIVED NOV 25 19  
District Health Office No.  
District File Number 1149-  
Case Filed

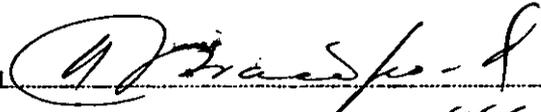
**STATEMENT BY LICENSED EMBALMER**

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.

Signed



Signed

Student Embalmer

Licensed Embalmer No. 4462

P. O. Address Street 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.