

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37893**

FILED NOV 29 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **3040** Registrar's No. **171**

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

1. PLACE OF DEATH a. COUNTY <b>LIVINGSTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>CARROLL</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Chillicothe</b>	c. LENGTH OF STAY (in this place) <b>25 da.</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Bogard</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Chillicothe Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>170</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Everett</b> b. (Middle) <b>Lesley</b> c. (Last) <b>Preston</b>	4. DATE OF DEATH (Month) <sup>th</sup> (Day) (Year) <b>NOV 18 1949</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>JAN 9-1867</b>	9. AGE (In years last birthday) <b>82</b>	10. UNDER 1 YEAR Months <b>10</b> Days <b>9</b>	11. UNDER 1 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (If by kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired carpenter</b>	11. BIRTHPLACE (State or foreign country) <b>Chillicothe, MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JAMES Preston</b>	13b. MOTHER'S MAIDEN NAME <b>SUSANNAH Scott</b>	14. NAME OF HUSBAND OR WIFE <b>NANNIE V. Preston</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Walter Preston</b>	ADDRESS <b>Kansas City, Mo.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>331X</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Congenital Heart failure</b> DUE TO (c)		
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 type="checkbox"/>
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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)
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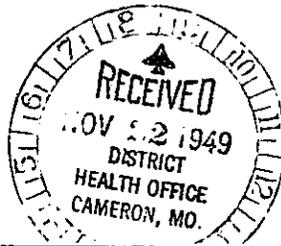
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **9 Nov, 1949**, to **18 Nov, 1949**, that I last saw the deceased alive on **18 Nov, 1949**, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>V. D. Nardine, D.M.D.</b>	23b. ADDRESS <b>Chillicothe, Mo.</b>	23c. DATE SIGNED <b>19 Nov 1949</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Nov 21, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Avalon</b>	24d. LOCATION (City, town, or county) (State) <b>Avalon, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Nov-19-49</b>	REGISTRAR'S SIGNATURE <b>Frances O. Neale</b>	171	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. A. Harker</b>	ADDRESS <b>Bogard, Mo.</b>
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**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 E. A. Dickerson

Signed.....  
Student Embalmer

Licensed Embalmer No. 2534

P. O. Address Boyard m

**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.