

FILED DEC 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41649**

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 180

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Linn</u>	
c. LENGTH OF STAY (In this place) <u>2 yrs</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>County Infirmary</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Dorsey</u> c. (Last) <u>Singleton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 23, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	
8. DATE OF BIRTH <u>Apr 21, 1875</u>		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	

13a. FATHER'S NAME <u>John Singleton</u>		13b. MOTHER'S MAIDEN NAME <u>Viola Stevenson</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa</u>	
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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) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Fay Bookman, Laclede Mo.</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES <u>Arterio sclerosis about 10 yrs</u> DUE TO (b) <u>Stroke dementia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Stroke dementia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Nov 1, 1949</u> <u>3/31X</u> <u>1 yr</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None done</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>Chillicothe Livingston Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Nov 1, 1949, to Nov 23, 1949, that I last saw the deceased alive on Nov 22, 1949, and that death occurred at 6 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. C. Cashner M.D.</u>		23b. ADDRESS <u>Chillicothe Mo</u>		23c. DATE SIGNED <u>Nov 26, 1949</u>	
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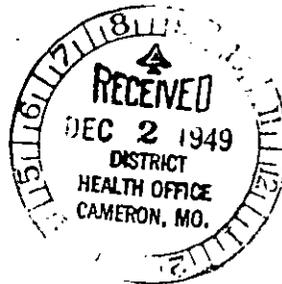
24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-25-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive</u>	
24d. LOCATION (City, town, or county) (State) <u>Purdin, Missouri</u>					

DATE REC'D BY LOCAL REG. <u>Nov-26-49</u>		REGISTRAR'S SIGNATURE <u>Francis B Neill</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Brother's Funeral Home, Laclede Mo</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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1
2



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. R. Wright*

Licensed Embalmer No. *4655*

P. O. Address *Laclede 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.