

No. 300
10. 48

FILED JAN 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41677**

61
32

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

BIRTH NO. _____		REG. DIST. NO. <u>200</u>		PRIMARY REG. DIST. NO. <u>3041</u>		Registrar's No. <u>138</u>			
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Macon</u>		c. LENGTH OF STAY (In this place) <u>5 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Narrows</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Samaritan Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>5 Miles S.E. of Macon, MO</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Stewart</u>			b. (Middle) _____			c. (Last) <u>Christal</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 22, 1949</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			
8. DATE OF BIRTH <u>July 1, 1886</u>		9. AGE (In years last birthday) <u>63</u>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 12 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>Farming</u>			11. BIRTHPLACE (State or foreign country) <u>Macon Co., Mo.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13a. FATHER'S NAME <u>John Christal</u>		13b. MOTHER'S MAIDEN NAME <u>Stevens</u>			
14. NAME OF HUSBAND OR WIFE <u>Nellie Christal</u>				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 <u>Mrs. Nellie Christal</u>				18. ADDRESS <u>RFD Macon, Mo.</u>		19. MEDICAL CERTIFICATION			
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.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>				<u>331X</u> <u>?</u>	
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) (Min.)		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 <u>Dec 22, 1949</u> , to <u>Dec 22, 1949</u> , that I last saw the deceased alive on <u>Dec 22, 1949</u> , and that death occurred at <u>7:00 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Howard Miller MD</u>				23b. ADDRESS <u>Macon</u>		23c. DATE SIGNED <u>1/27/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/26/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Macon Co. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>12/28/49</u>		REGISTRAR'S SIGNATURE <u>Clara Mcneely</u>		FEE <u>1.25</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Allent Skinner</u>			
						ADDRESS <u>Macon Mo.</u>			

(Licensed Emballer's Statement on Reverse Side)

RECEIVED 1/3/50
MACON COUNTY HEALTH DEPARTMENT

County File No. 1/50/4

Date Filed 1/5/50

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 Oellint B Keener

Licensed Embalmer No. 7571

P. O. Address Macon 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.