

FILED JAN 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13660**
 BIRTH NO. _____ REG. DIST. NO. 135 PRIMARY REG. DIST. NO. 5497 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison 10410	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Blythedale		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Marion Twp	
c. LENGTH OF STAY (In this place) 3 Wks		d. STREET ADDRESS (If rural, give location) South East 1/2 mile Blythe.	
d. FULL NAME OF HOSPITAL OR INSTITUTION none			

3. NAME OF DECEASED (Type or Print) a: (First) Samuel b. (Middle) M c. (Last) Street-			4. DATE OF DEATH (Month) (Day) (Year) July 13, 1949		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 8, 1878	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months 3 Days 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZENRY OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME George Street	13b. MOTHER'S MAIDEN NAME Mary Drohen	14. NAME OF HUSBAND OR WIFE Rosé
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or date of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Lillie Martin, Blythedale, Mo.	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-renal Syndrome		5 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis DUE TO (c) Senility		apro.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		442X	

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) m.	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 Dec, 1944, to 7-11, 1949, that I last saw the deceased alive on 7-11, 1949, and that death occurred at 1:55 am., from the causes and on the date stated above.

23a. SIGNATURE J. B. Hyer, D.D.	(Degree or title)	23b. ADDRESS Eagleville Mo.	23c. DATE SIGNED 7-14-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-14-1949	24c. NAME OF CEMETERY OR CREMATORY Eagleville	24d. LOCATION (City, town, or county) (State) Eagleville, Mo.
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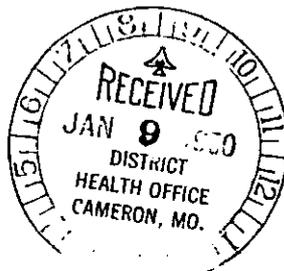
DATE REC'D BY LOCAL REG. July 14 1949	REGISTRAR'S SIGNATURE Leola Brewer 118	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Hays Eagleville Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

300

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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.

Student
Student Embalmer

Signed M. B. Haas

M. B. Haas.
Licensed Embalmer No. 3899

P. O. Address Bethany, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.