

FILED FEB 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4401

5320

BIRTH NO. _____		REG. DIST. NO. <u>29</u>		PRIMARY REG. DIST. NO. <u>4171</u>		Registrar's No. <u>8</u>	
1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clarksdale</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clarksdale</u>		<u>0-320</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location) <u>2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Laurence</u> c. (Last) <u>White</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb, 2 1950</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>Mar. 27, 1876</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Station</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>John White</u>		13b. MOTHER'S MAIDEN NAME <u>Milisa Gihbart</u>		14. NAME OF HUSBAND OR WIFE <u>Katie White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S SIGNATURE OR NAME <u>Katie White</u>		ADDRESS <u>Clarksdale Mo</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid 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. INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>4201</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.)		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>Feb 2, 1950</u> , to <u>Feb 2, 1950</u> that I last saw the deceased alive on <u>Feb 2, 1950</u> , and that death occurred at <u>5:30 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (In blue or black ink) <u>Dr. Starnold Fowler D.O.</u>				23b. ADDRESS <u>Mayssville Mo</u>		23c. DATE SIGNED <u>2-3-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-5-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Amity</u>		24d. LOCATION (City, town, or county) (State) <u>Amity Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-16-50</u>		REGISTRAR'S SIGNATURE <u>Asurk Dawson</u>		52. FUNERAL DIRECTOR'S SIGNATURE <u>John Beers</u>		ADDRESS <u>Mayssville Mo</u>	

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



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.....
Student Embalmer

Signed *John Beaman*
Licensed Embalmer No. *3983*
P. O. Address *Wassouille 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.