

FILED MAR 6 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 73817

1050

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4515 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Milan</u> <u>1050</u>	
c. LENGTH OF STAY (in this place) <u>894 1/2</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nancy</u> b. (Middle) <u>Castilia</u> c. (Last) <u>Compton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 18 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-3-1862</u>
9. AGE (In years last birthday) <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>James Glidewell</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Black</u>	14. NAME OF HUSBAND OR WIFE <u>James Compton - dead</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.	17. INFORMANT'S SIGNATURE OR NAME <u>Ann Compton</u> ADDRESS <u>Milan Mo</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatis pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mixed respiratory infection (common cold)</u>			<u>2 weeks</u>
DUE TO (c) <u>Dorsal spine compression, due to trauma, (invalid)</u>			<u>522X</u> <u>about 4 yrs.</u>
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 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)		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>7-30</u> , 19 <u>47</u> , to _____, 19____, that I last saw the deceased alive on <u>2-17</u> , 19 <u>50</u> , and that death occurred at <u>2 a</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Joseph P. Prior</u> (Degree or title)		23b. ADDRESS <u>P.O. Box 82, Milan, Mo.</u>	
23c. DATE SIGNED <u>2-20-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>2/20/50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Harley Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Milan Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-28-50</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u> <u>320</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Shoens</u> ADDRESS <u>Saight Shoens</u>			

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

MAR 2 1950

RECEIVED

District Health Officer No. 1

District File Number 2-52-37

Date Filed MAR 2 1950

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 Dwight Schoene.....

Licensed Embalmer No. 2667.....

P. O. Address Windsor - MI.....

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.