No. 300
0.48

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

FILED MAY 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15856

BIRTH NO. _____ REG. DIST. NO. 32 PRIMARY REG. DIST. NO. 5112 Registrar's No. 45

1. PLACE OF DEATH
a. COUNTY Bollinger
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Lorance
c. LENGTH OF STAY (in this place) 2 yr 9 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Stoddard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Duck Creek 1030 1
d. STREET ADDRESS (If rural, give location) Kinder Mo

3. NAME OF DECEASED (Type or Print)
a. (First) Robert
b. (Middle) E. Lee
c. (Last) Sheeley

4. DATE OF DEATH (Month) May (Day) 1 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Jan. 20 1880
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR: Months 3, Days 11 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (State or foreign country) Stoddard Co Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Scott Gillespie
13b. MOTHER'S MAIDEN NAME Florence Lewis
14. NAME OF HUSBAND OR WIFE ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Mrs Kay Daniels **ADDRESS** Puxico Mo

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiovascular Renal Disease (supp. report)
DUE TO (c)

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 ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/12/50, 19___, *to* 4/29/50, 19___, *that I last saw the deceased alive on* 4/5/50, 19___, *and that death occurred at* 9:20 p m., *from the causes and on the date stated above.*

23a. SIGNATURE John D Morris (Degree or title) DO
23b. ADDRESS Sikeston Mo
23c. DATE SIGNED 5/11/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE May 3-50
24c. NAME OF CEMETERY OR CREMATORY Fagan Cemetery
24d. LOCATION (City, town, or county) Stoddard Co. (State) Mo

DATE REC'D BY LOCAL REG. May 18, 1950
REGISTRAR'S SIGNATURE Willie Van Quinkerkerk
25. FUNERAL DIRECTOR'S SIGNATURE Floyd Morgan **ADDRESS** Puxico Mo

(Licensed Embalmer's Statement on Reverse Side)

[illegible] Office No.
550-714

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 Ira E. Meadows

Licensed Embalmer No. 4637

P. O. Address Purdie, Mo.

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

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