No. 300
10-48

FILED JUN 22 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19811

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5376 Registrar's No. 36

1. PLACE OF DEATH
a. COUNTY: DeKalb
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Grand River
c. LENGTH OF STAY (in this place): 10 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: DeKalb.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Grand River.
d. STREET ADDRESS (If rural, give location): 0370

3. NAME OF DECEASED (Type or Print) a. (First): Dana b. (Middle): Jeane c. (Last): Daniels.

4. DATE OF DEATH (Month) (Day) (Year): June 5 1950

5. SEX: Female
6. COLOR OR RACE: Wh.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: Aug. 2 - 1949
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months 10, Days 3 — IF UNDER 24 HRS.: Hours, Min.

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

13a. FATHER'S NAME: David Daniels
13b. MOTHER'S MAIDEN NAME: Bonie Jeane Wilcox
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. —
17. INFORMANT'S SIGNATURE OR NAME: Jewel Daniels — ADDRESS: Cameron 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) Meningitis - non specific — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ruptured Spina bifida
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 3403

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* Aug 2, 1949, *to* 6-5, 1950, *that I last saw the deceased alive on* 6-4, 1950, *and that death occurred at* 12:45 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: R E Wilbur (Degree or title) Mo
23b. ADDRESS: Cameron Mo
23c. DATE SIGNED: 6-7-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 6-50
24c. NAME OF CEMETERY OR CREMATORY: Lathrop
24d. LOCATION (City, town, or county) (State): Lathrop Mo.

DATE REC'D BY LOCAL REG.: 6-26-50
REGISTRAR'S SIGNATURE: Roscoe Dawkins 82 0
25. FUNERAL DIRECTOR'S SIGNATURE: DeMoss Crunk — ADDRESS: Cameron Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
JUN 19 1950
DISTRICT
HEALTH OFFICE
CAMERON, MO.

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 Laurence F. Thompson

Licensed Embalmer No. 4725

P. O. Address Cameron, 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.