

FILED JUL 19 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

22608

State File No. 107

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Annawan</u>	
c. LENGTH OF STAY (In this place) <u>6 days</u>		d. STREET ADDRESS (If rural, give location) <u>8</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>KCOS Hospital</u>			
3. NAME OF DECEASED a. (First) <u>Harold</u> b. (Middle) <u>Lee</u> c. (Last) <u>Aull</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 6 1950</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>August 5, 1904</u>
9. AGE (In years last birthday) <u>45</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Chambers Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Lon Aull</u>	13b. MOTHER'S MAIDEN NAME <u>Nora Brown</u>
14. NAME OF HUSBAND OR WIFE <u>Mrs. Ella Aull---wife</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. <u>yes U.K.</u>
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ella Aull</u>		ADDRESS <u>Annawan Ill</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, asphyxia, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</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. <u>Cholecystectomy</u>		<u>586 X</u>	
19a. DATE OF OPERATION <u>July 2 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Stenosis of cystic duct due to adhesions</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	
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) (Min.) _____		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>July 1, 1950</u> , to <u>July 6, 1950</u> , that I last saw the deceased alive on <u>July 6, 1950</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>H. Hooper M.D.</u>		23b. ADDRESS <u>Kirkville Mo</u>	
23c. DATE SIGNED <u>7-6-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-7-50</u>	
24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY <u>Annawan</u>	
24d. LOCATION (City, town, or county) (State) <u>Annawan Ill.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Davis, Kirkville, Mo</u>	
DATE REC'D BY LOCAL REG. <u>7-6-50</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Davis, Kirkville, Mo</u>		ADDRESS _____	

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

JUL 19 1950

RECEIVED JUL 11 1950
District Health Officer No. 70
District File Number 7-50-1101
Date Filed JUL 14 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 _____

working under my personal supervision.

Student Embalmer No.

Signed Robert B. Davis

Signed
Student Embalmer

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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.