

No. 300
10-25-50

FILED AUG 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23950

State File No.

BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 5662 Registrar's No. 57

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Lewis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Knox | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - La Belle Twp. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hurdland, Mo. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Prairie View Rest Home | | d. STREET ADDRESS (If rural, give location) 1 | |

| | | | | |
|-------------------------------------|----------------------------|----------------------------|-----------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Caroline | b. (Middle) Elliott | c. (Last) Fast | 4. DATE OF DEATH (Month) (Day) (Year) July 11 1950 |
|-------------------------------------|----------------------------|----------------------------|-----------------------|---|

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|-----------------|---------------------------|---|-------------------------------------|---|------------------------|-----------------------|-------|------|
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH May 26 1873 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Days | Hours | Min. |
|-----------------|---------------------------|---|-------------------------------------|---|------------------------|-----------------------|-------|------|

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|--|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY housekeeper | 11. BIRTHPLACE (State or foreign country) Macon Co., Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
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|--|--|---|
| 13a. FATHER'S NAME Daniel Elliott | 13b. MOTHER'S MAIDEN NAME Louisa Wyer | 14. NAME OF HUSBAND OR WIFE John M. Fast |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME James R. Fast | ADDRESS Hurdland Mo. |
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| 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. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-vascular-renal disease | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | 42X |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bright's Disease | | | |

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|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

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|--|--|---|
| 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) |
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| | | |
|--|--|----------------------------|
| 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 **July 7, 1950**, to **July 11, 1950**, that I last saw the deceased alive on **July 9, 1950**, and that death occurred at **9:30A. m.**, from the causes and on the date stated above.

| | | |
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| 23a. SIGNATURE Harry S. McBrook (Degree or title) D.O. | 23b. ADDRESS La Belle, Missouri | 23c. DATE SIGNED 7/21/50 |
|--|--|---------------------------------|

| | | | |
|--|----------------------------|---|---|
| 24a. BURIAL / CREMATION, REMOVAL (Specify) burial | 24b. DATE 7/14 1950 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Tabor | 24d. LOCATION (City, town, or county) (State) 7 mi S. Hurdland Mo. |
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| DATE REC'D BY LOCAL REG. 7-19-50 | REGISTRAR'S SIGNATURE R. W. Jensen | 25. HEALTH DIRECTOR'S SIGNATURE W. H. ... | ADDRESS Hurdland Mo. |
|---|---|--|-----------------------------|

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

X-

N.S.

RECEIVED

JUL 24 1958

District Health Officer No. 4

District File Number 7-50-1212

Date Filed JUL 1 1958

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 Geoff W. Casey Jr.

Licensed Embalmer No. 3755

P. O. Address Hurdland, T.

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.