FILED AUG 3 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24089

BIRTH NO. _____ REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 5780 Registrar's No. 38

1. PLACE OF DEATH
a. COUNTY: Miller
b. CITY OR TOWN: Eldon — Township: Saline — c. LENGTH OF STAY (in this place): 4 yrs
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: Miller
c. CITY OR TOWN: Eldon — Township: Saline Twp
d. STREET ADDRESS (If rural, give location): 06

3. NAME OF DECEASED (Type or Print): a. (First) Pearl — b. (Middle) Amy — c. (Last) Jarrett

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: August 9, 1903
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months 11 Days 23 — IF UNDER 24 HRS.: Hours ___ Min. ___

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

13a. FATHER'S NAME: James Hicks
13b. MOTHER'S MAIDEN NAME: Rachel Dake
14. NAME OF HUSBAND OR WIFE: Charles Jarrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 486-30-8184
17. INFORMANT'S SIGNATURE OR NAME: Charles Jarrett — ADDRESS: Eldon, Mo. Star Rt.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of the liver — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Ascites — 3 months
DUE TO (c)

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

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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 _____, 19___, to _____, 19___, that I last saw the deceased alive on July 17, 1950, and that death occurred at 4:40 P m., from the causes and on the date stated above.*

23a. SIGNATURE: Walter Hedges (Degree or title): Coroner
23b. ADDRESS: Iberia, Missouri
23c. DATE SIGNED: 7/18/50

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 7/19/50
24c. NAME OF CEMETERY OR CREMATORY: Jarrett Cemetery
24d. LOCATION (City, town, or county) (State): Miller County, Missouri

DATE REC'D BY LOCAL REG.: July 25, 1950
REGISTRAR'S SIGNATURE: Florence M. Stevens
25. FUNERAL DIRECTOR'S SIGNATURE: Walter Hedges
ADDRESS: Iberia, Missouri

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

AUG 1 1950

MILLER COUNTY HEALTH
DEPARTMENT

SEP 20

JAN 9 19

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 Walter P. Hedges

Licensed Embalmer No. 4265

P. O. Address Iberia, Mo

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

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