

No. 300
10.48

FILED AUG 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24244

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 247

1. PLACE OF DEATH a. COUNTY <i>Pettis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>Pettis</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Sedalia</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>Houstonia 1800</i>	
c. LENGTH OF STAY (In this place) <i>1 day</i>		d. STREET ADDRESS (If rural, give location) <i>1</i>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Bathwell Hospital</i>			
3. NAME OF DECEASED (Type or Print) a. (First) <i>Minnie</i>		b. (Middle) <i>Maude</i>	
c. (Last) <i>Cozts</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>July 19 50</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>July 29 1878</i>
9. AGE (In years last birthday) <i>72</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Knacker</i>	11. BIRTHPLACE (State or foreign country) <i>Pettis Co Mo</i>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <i>U S</i>
13a. FATHER'S NAME <i>William McAndrews</i>		13b. MOTHER'S MAIDEN NAME <i>Ann Murray</i>	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 NUMBER <i>500-10-004</i>	17. INFORMANT'S SIGNATURE, OR NAME AND ADDRESS <i>Wm. L. Skillman Houstonia Mo</i>
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>diabetes.</i> ANTECEDENT CAUSES DUE TO (b) <i>Diabetic Coma.</i> DUE TO (c) <i>Diabetic Gangrene of Right Leg.</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic Myocarditis. Senility.</i>	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours.</i> <i>3 days.</i> <i>?</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>Medical treatment only. Over please.</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>None.</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>2107X</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>None.</i>		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 <i>July 18th, 19 50</i> , to <i>July 19th, 19 50</i> , that I last saw the deceased alive on <i>July 19th, 19 50</i> , and that death occurred at <i>8.30 Am.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Jno. B. Carlisle, M.D.</i>		23b. ADDRESS (Degree or title) <i>Jno. B. Carlisle, M.D. Sedalia, Missouri.</i>	
23c. DATE SIGNED <i>7-21-50.</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>7-21-50</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>La Monte</i>		24d. LOCATION (City, town, or county) (State) <i>La Monte Mo</i>	
DATE REC'D BY LOCAL REG. <i>7/21-1950</i>		REGISTRAR'S SIGNATURE <i>J. J. Campbell</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Campbell</i>		ADDRESS <i>251 Westbrook Houstonia</i>	

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

(Licensed Embalmer's Statement on Reverse Side)

This lady has been a patient of Dr. Parkhurst at Houstonia for many years and has been treated for the conditions mentioned on the other side. Some two days before admittance her right leg became swollen and Dr. Parkhurst because he could not get her well sent her in hospital for further care and treatment. She was in the hospital about twenty hours before she died. Little could be done for her.

RECEIVED
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed _____

Dr. Jno. B. Carlisle,
Jno. B. Carlisle M.D.
Sedalia, Missouri, July 21st, 1950.

RECEIVED
DISTRICT HEALTH OFFICE No. _____
District File Number _____
Date Filed 7-31-50

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.

Signed _____
Student Embalmer

Signed *H. Knibley*

Licensed Embalmer No. 3987

P. O. Address Houstonia

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.