

FILED AUG 28 1950

THE DIVISION OF HEALTH OF THE STATE OF TEXAS
STANDARD CERTIFICATE OF DEATH

State File No. 29194

BIRTH NO. _____ REG. DIST. NO. 353 PRIMARY REG. DIST. NO. 6196 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Kans</u> b. COUNTY <u>Johnson</u>	
b. CITY OR TOWN <u>Russell-Sherrill</u>		c. CITY OR TOWN <u>Stalhe</u>	
c. LENGTH OF STAY (in this place or township) <u>3 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>1600 E. Park St</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) <u>WILLIAM E. SURBER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 14 1950</u>		
a. (First)		b. (Middle)		c. (Last)	

5. SEX <u>Male</u>	6. COLOR OF RACE <u>Indian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-6-1913</u>	9. AGE (In years) (Month) (Day) (Year) <u>37</u>	10. UNDER 1 YEAR	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hoop Tenn</u>		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <u>Henley Surber</u>	13b. MOTHER'S MAIDEN NAME <u>Ellie Williams</u>	14. NAME OF HUSBAND, OR WIFE <u>M. Marie Clathier</u>
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>M. Marie Surber</u>	ADDRESS <u>Kans</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Guns shot</u>	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>E981X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) <u>Homicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home, Hoop, Tenn</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Licking Texas Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 14 1950 11:00 AM</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Shot with Rifle</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edna J. Elliott</u> (Degree or title) <u>3 (Nurse)</u>	23b. ADDRESS <u>Central Mo</u>	23c. DATE SIGNED <u>Aug 16/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-18-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Boone Creek Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Texas Co. Mo</u>
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DATE REC'D BY LOCAL REG. <u>Aug 17, 1950</u>	REGISTRAR'S SIGNATURE <u>Alvora Hesse</u>	324	25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) <u>Smith & Trauson Licking Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED AUG 22 1950

Dist. File 850-1012

Date Filed 8-22-50

VS JAN 20 1964

AUG 28 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed

Embert C. Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking 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.