

FILED OCT 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 340913

BIRTH NO. _____		REG. DIST. NO. 200		PRIMARY REG. DIST. NO. 2041		Registrar's No. 125			
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Macon</u>		c. LENGTH OF STAY (in this place) <u>10 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Macon</u>		0612			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>215 Sheridan</u>				d. STREET ADDRESS (If rural, give location) <u>215 Sheridan</u>					
3. NAME OF DECEASED (Type or Print) <u>John</u>		a. (First) <u>John</u>		b. (Middle) <u>W.</u>		c. (Last) <u>Teoley</u>			
4. DATE OF DEATH <u>Sept. 28 1950</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			
8. DATE OF BIRTH <u>July 2, 1860</u>		9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR: MONTHS _____ DAYS _____		IF UNDER 100 HRS.: HOURS _____ MIN. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Shelby Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>C. S. Teoley</u>		13b. MOTHER'S MAIDEN NAME <u>Lou Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Teoley</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Anna Teoley</u>		ADDRESS <u>Macon, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Frigidity</u>				DUPLICATE (b) <u>Arterio-sclerosis</u>				<u>2 weeks</u>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE (c) <u>Senile Debility</u>				—	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4-2-1				—	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (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>Jan</u> , 1950, to <u>Sept 28, 1950</u> , that I last saw the deceased alive on <u>Sept 28, 1950</u> , and that death occurred at <u>9:02 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Dr. E. S. ...</u>				23b. ADDRESS <u>Macon, Mo.</u>		23c. DATE SIGNED <u>10/2/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/30/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Graves Chapel</u>		24d. LOCATION (City, town, or county) (State) <u>Macon Co. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>10/14/50</u>		REGISTRAR'S SIGNATURE <u>Beth McNeely</u>		185		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin Skinner</u>		ADDRESS <u>macon</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 10-24-50
MACON COUNTY HEALTH DEPARTMENT
County File No. 10-50-192
Date Filed 10-26-50

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon

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.