

FILED OCT 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34255**
Registrar's No. **212**

BIRTH NO. _____ REG. DIST. NO. **251** PRIMARY REG. DIST. NO. **3848**

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Parnell	
c. LENGTH OF STAY (in this place) 9 days		d. STREET ADDRESS (If rural, give location) 1130	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		4. DATE OF DEATH (Month) (Day) (Year) 10 11 1950	
3. NAME OF DECEASED (Type or Print) a. (First) Nettie	b. (Middle) Jane	c. (Last) Herndon	5. SEX female
6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2 12 1877	9. AGE (In years last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY housekeeping	11. BIRTHPLACE (State or foreign country) Oxford, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Dal White	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Frank Herndon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Frank Herndon Parnell, Mo.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Colon ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR?	
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 <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 May , 19 50 , to 10-11 , 19 50 , that I last saw the deceased alive on 10-11 , 19 50 , and that death occurred at 3:40 m., from the causes and on the date stated above.			
23a. SIGNATURE Frank B. Matteson (Degree or title) md		23b. ADDRESS Grant City Mo	23c. DATE SIGNED 10/13/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10 13 1950	24c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	24d. LOCATION (City, town, or county) (State) Grant City, Mo.
DATE REC'D BY LOCAL REG. 10-21-50	REGISTRAR'S SIGNATURE Bess Holt	25. FUNERAL DIRECTOR'S SIGNATURE Arch C. Sample ADDRESS Grant City, Mo.	

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



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 _____

Arch C. Dwyer

Licensed Embalmer No. _____

3252

P. O. Address _____

Grant City, 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.