

FILED OCT 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34327

BIRTH NO.		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 3052		Registrar's No. 327	
1. PLACE OF DEATH a. COUNTY PETTIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY PETTIS			
b. CITY OR TOWN SEDALIA		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN SEDALIA		0830	
d. FULL NAME OF HOSPITAL OR INSTITUTION BUENA VISTA				d. STREET ADDRESS (If rural, give location) RURAL NORTH OF SEDALIA			
3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle) FRANCIS		c. (Last) ALFTER		4. DATE OF DEATH (Month) (Day) (Year) Oct. 16, 1950	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Oct. 14, 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Saline, County.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Adolph Alfter		13b. MOTHER'S MAIDEN NAME Rheuhel R. Murray		14. NAME OF HUSBAND OR WIFE None			
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 ADDRESS Mrs. Price Hayworth, Sedalia, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of Prostate ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Operation 1 year ago DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 177X				INTERVAL BETWEEN ONSET AND DEATH	
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)		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 Sept 1, 1950, to Oct 16, 1950, that I last saw the deceased alive on Oct 11, 1950, and that death occurred at 7:05 P m., from the causes and on the date stated above.							
23a. SIGNATURE E. C. Survery M.D.		23b. ADDRESS Sedalia Mo		23c. DATE SIGNED Oct 17-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Oct. 18, 1950		24c. NAME OF CEMETERY OR CREMATORY Houstonia Cemetery		24d. LOCATION (City, town, or county) (State) Houstonia, Mo	
DATE REC'D BY LOCAL REG. 10-18-1950		REGISTRAR'S SIGNATURE W. Campbell M.D.		FURNERAL DIRECTOR'S SIGNATURE W. Beckert		ADDRESS Sedalia, Mo.	

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED 10-23-50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 10-23-50

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.

Student _____
Student Embalmer

Signed

W. H. Hekart

Licensed Embalmer No. 3470

P. O. Address

Seidalia, 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.