

FILED NOV 30 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36001

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 316

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>9120</u>	
b. CITY OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Decatur</u>	
c. LENGTH OF STAY (in this place) <u>11 mo 19 days</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home</u>			
3. NAME OF DECEASED a. (First) <u>ALLAN</u> b. (Middle) <u>JOHN</u> c. (Last) <u>AMES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 19 1950</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 9 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	9. AGE (In years last birthday) <u>84</u>
		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Thomas Ames</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Delsell</u>	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 NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records Kirksville, Mo</u> ADDRESS
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Petechial Cerebral Hemorrhage</u> <u>2 weeks</u>	
		DUE TO (c) <u>Cerebral Arteriosclerosis</u> <u>2-5 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		<u>Prostatic, Pelvic, &amp; Lung Malignancy</u> <u>1-2 yrs</u>	
19a. DATE OF OPERATION <u>Nov 19, 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Petechial Cerebral Hemorrhage, Prostatic, Pelvic &amp; Lung Cancer</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>162X</u>	
22. I hereby certify that I attended the deceased from <u>Feb 6</u> , 1950, to <u>Nov 19</u> , 1950, that I last saw the deceased alive on <u>Nov 18</u> , 1950, and that death occurred at <u>6:00 A. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Vincent J. Straigo</u> (Degree or title) <u>D. O.</u>		23b. ADDRESS <u>Community Nursing Home</u>	23c. DATE SIGNED <u>Nov 20, 1950</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-20-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Kirksville Mo.</u>
DATE REC'D BY LOCAL REG. <u>11-20-50</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Davis</u> ADDRESS <u>Kirksville Mo.</u>	

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

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Date Received: NOV 27 1960  
DISTRICT HEALTH OFFICE #2  
District File Number 11-60-2003  
Date Filed: NOV 28 1960

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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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Hicksville, 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.