

FILED DEC 7 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36553

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5356 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Long Lane Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Long Lane Rural</u>	
c. LENGTH OF STAY (in this place) <u>40 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>0320</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CLYDE</u>	b. (Middle) <u>MONROE</u>	c. (Last) <u>DEKARD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-14-1950</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>9-14-1891</u>	9. AGE (In years last birthday) <u>59</u> Months <u>2</u>	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
--------------------	-------------------------------	---	-----------------------------------	---	----------------------	------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	---	---	---

13a. FATHER'S NAME <u>Sigel DeKard</u>	13b. MOTHER'S MAIDEN NAME <u>Rudie Anglin</u>	14. NAME OF HUSBAND OR WIFE <u>Hattie</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>558-162928</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Clyde DeKard</u>	ADDRESS <u>Buffalo 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Osteogenic Sarcoma</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>unknown</u> DUE TO (c) <u>unknown</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		196X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input 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?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Aug 1, 1950, to Nov 14, 1950, that I last saw the deceased alive on Sept 1, 1950, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>G. B. Plummer</u> (Degree or title)	23b. ADDRESS <u>Buffalo Mo</u>	23c. DATE SIGNED <u>11-18-50</u>
---	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY <u>Uteel</u>	24d. LOCATION (City, town, or county) (State) <u>Dallas Co Mo</u>
---	-----------	---	---

DATE REC'D BY LOCAL REG. <u>11/27/50</u>	REGISTRAR'S SIGNATURE <u>Wm J. B. Jones</u> 80	25. FUNERAL DIRECTOR'S SIGNATURE <u>L B Jones</u> ADDRESS <u>Buffalo Mo</u>
--	--	---

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

13000  
1

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

RECEIVED NOV 29 1950

Dist. File 1250-2364

Date Filed 12-5-50

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 Mrs B Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo

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.