

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 13 1950

BIRTH NO. _____ REG. DIST. NO. 135 PRIMARY REG. DIST. NO. 4210 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ridgeway		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ridgeway	
c. LENGTH OF STAY (in this place) 10 yr		d. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF HOSPITAL OR INSTITUTION none			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Samuel	b. (Middle) Clinton	c. (Last) Whitehead	April 20, 1950		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1-6-1872	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 3
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) Daviess County, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Whitehead	13b. MOTHER'S MAIDEN NAME Elizabeth Wise	14. NAME OF HUSBAND OR WIFE Elizabeth Ann Whitehead
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Ann Whitehead	ADDRESS Ridgeway
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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 3 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4221			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	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) (Minute) None	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 Dec. 14, 1945, to Apr. 20, 1950; that I last saw the deceased alive on Apr. 20, 1950, and that death occurred at 5:15 A. m., from the causes and on the date stated above.

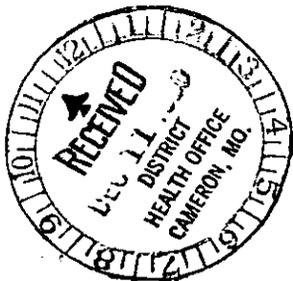
23a. SIGNATURE Leki Brewer, M.D.	(Degree or title)	23b. ADDRESS Ridgeway, Mo.	23c. DATE SIGNED Apr. 21, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-22-1950	24c. NAME OF CEMETERY OR CREMATORY Miriam	24d. LOCATION (City, town, or county) (State) Bethany, Mo.
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DATE REC'D BY LOCAL REG. Apr. 21, 1950	REGISTRAR'S SIGNATURE Leki Brewer	118	25. FUNERAL DIRECTOR'S SIGNATURE McNaam	ADDRESS Bethany Mo.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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 *M. S. HARR*
M. S. HARR

Licensed Embalmer No. 3899

P. O. Address Bethany, 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.