

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **39574**

FILED DEC 12 1950

BIRTH NO. _____		REG. DIST. NO. <u>398</u>		PRIMARY REG. DIST. NO. <u>6176</u>		Registrar's No. <u>867</u>	
1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Humphreys Taylor</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Humphreys</u>		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>Taylor Tur.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MRS IDA</u>		b. (Middle) <u>HARDING</u>		c. (Last) <u>ALLEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11-26-50</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug 22 1876</u>	9. AGE (In years last birthday) <u>74</u>	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 14 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Greene Co. Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>W. F. Harding</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Crawford</u>		14. NAME OF HUSBAND OR WIFE <u>G. V. Allen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>G. V. Allen Humphreys 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis chronic</u> (b) <u>Arterio Sclerosis</u> 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. <u>429.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) _____		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 <u>1-1-1950</u> , to <u>11-26-1950</u> that I last saw the deceased alive on <u>11-25, 1950</u> , and that death occurred at <u>2:45 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. C. Weston, M.D.</u>		23b. ADDRESS <u>Galt, Mo</u>				23c. DATE SIGNED <u>11-27-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burn</u>		24b. DATE <u>11-29-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Humphreys Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Humphreys Mo</u>	
DATE REC'D BY LOCAL REG. <u>Dec 2</u>		REGISTRAR'S SIGNATURE <u>Greta Caldwell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. K. Taylor</u>		ADDRESS <u>Galt Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Ms APR 23 1959

Date Received: DEC 5 1950
DISTRICT HEALTH OFFICE #2
District File Number 12-56-2
Date Filed: DEC 7 1950

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

PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address

Galt

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.