

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39716

FILED DEC 22 1950

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 5003 Registrar's No. 331

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Morrow Twnsp.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Novinger Rt. 2</u>	
c. LENGTH OF STAY (in this place) <u>years</u>		d. STREET ADDRESS (If rural, give location) <u>5 miles west of Novinger</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home, Novinger Rt. 2.</u>			

3. NAME OF DECEASED (Type or Print) <u>ANNA</u>			a. (First)	b. (Middle)	c. (Last) <u>COGLEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 8- 1950</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>		8. DATE OF BIRTH <u>August 22, 1859</u>	9. AGE (In years last birthday) <u>91</u>	if UNDER 1 YEAR Months	if UNDER 24 HRS. Hours	if UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Clarion County, Penn./</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>James McKeo</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah McCalla</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Francis Cogley, Novinger, Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic mitral stenosis</u>			INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senile debility</u> DUE TO (c) <u>Staphylococcus</u>				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arterial sclerosis -</u>			<u>4/0X</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 _____, 1948, to Nov 7, 1950, that I last saw the deceased alive on Dec 7, 1950, and that death occurred at 8:40 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>J S Gashville M D</u> (Degree or title)		23b. ADDRESS <u>Novinger Mo</u>		23c. DATE SIGNED <u>12/10/50</u>	
---	--	---------------------------------	--	----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 3</u>		24b. DATE <u>12-11-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Laural Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Des Moines Iowa</u>	
--	--	---------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. <u>12-11-50</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert B Davis, Burlington, Mo.</u>	
--	--	---	--	---	--

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

Date Received: DEC 19
DISTRICT HEALTH OFFICE
District File Number 12-50
Date Filed: DEC 20 1958

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

Robert B. Davis

Signed.....

Student Embalmer

Licensed Embalmer No. *4219*

P. O. Address

Liberville, 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.