

State File No. **39817**

BIRTH NO.		REG. DIST. NO. 34		PRIMARY REG. DIST. NO. 5111		Registrar's No. 19	
1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Boone			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Cedar		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Cedar 0100			
d. FULL NAME OF HOSPITAL OR INSTITUTION Hartsburg R.F.D.				d. STREET ADDRESS (If rural, give location) Hartsburg R.F.D.			
3. NAME OF DECEASED (Type or Print) a. (First) Mead b. (Middle) Willis c. (Last) Alexander				4. DATE OF DEATH (Month) (Day) (Year) 11 30 1950			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 5-2-1852	
9. AGE (In years last birthday) 68		10. a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) Merchant grocery - retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY USA							
13a. FATHER'S NAME James Alexander				13b. MOTHER'S MAIDEN NAME Virginia Crump		14. NAME OF HUSBAND OR WIFE Elsie Alexander	
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 ADDRESS Elsie Alexander Hartsburg Mo	
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. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive cardio DUE TO (c) vascular disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 443X			
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 May, 1949, to Nov, 1950 that I last saw the deceased alive on Nov 30, 1950, and that death occurred at 10 P m., from the causes and on the date stated above.							
23a. SIGNATURE Le Roy J. Miller M.D. (Degree or title)				23b. ADDRESS Ashland Mo.		23c. DATE SIGNED Dec 8, 50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-3-1950		24c. NAME OF CEMETERY OR CREMATORY Bonds Chapel		24d. LOCATION (City, town, or county) (State) Boone Mo.	
DATE REC'D BY LOCAL REG. Dec 8/50		REGISTRAR'S SIGNATURE Mrs. Mildred Burnett		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. L. Burnett Ashland Mo			

RECEIVED 1222.50

DISTRICT HEALTH OFFICE No. 3

District File Number

Date 12-22-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 3564

P. O. Address _____

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.