

FILED MAR 26 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8015

1360  
4

BIRTH NO. _____		REG. DIST. NO. 114		PRIMARY REG. DIST. NO. 1432		Registrar's No. 9	
1. PLACE OF DEATH a. COUNTY Franklin - Missouri				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). STATE Mo b. COUNTY Franklin			
b. CITY (If outside corporate limits, write RURAL and give township) Sullivan Rural		c. LENGTH OF STAY (In this place) 10 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Sullivan Rural		360	
d. FULL NAME OF (If not in hospital or institution, give street address or location) Miller Nursing - 147				d. STREET ADDRESS Missouri			
3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle) A		c. (Last) Meeks		4. DATE OF DEATH (Month) 2 (Day) 27 (Year) 1951	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED, SEPARATED 1		8. DATE OF BIRTH Exact date unknown 1884	
9. AGE (In years last birthday) 67		10. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mamie Meeks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Emma Millard Supt. Miller Home Sullivan, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) upper respiratory infection ANTECEDENT CAUSES (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. pneumonia DUE TO (c) Paresis, legs. cord lesion				INTERVAL BETWEEN ONSET AND DEATH 2 days years	
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)		493X	
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 2-26, 1951, that I last saw the deceased alive on 2-26, 1951, and that death occurred at 7:30 p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Charles M. D. O.				23b. ADDRESS Sullivan - Mo		23c. DATE SIGNED 3-2-1951	
24a. BURIAL, CREMATION, REMOVAL (Specify) n		24b. DATE 3-2-1951		24c. NAME OF CEMETERY OR CREMATORY Presbyterian		24d. LOCATION (City, town, or county) (State) Gerald Franklin Mo	
DATE REC'D BY LOCAL REG. 3-2-51		REGISTRAR'S SIGNATURE C. A. Proctor M.D.		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS G. Meyer Gerald MO			

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

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

MAR 20 1951

RECEIVED

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 \_\_\_\_\_

*Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed *Harvey Kahle* \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.