

FILED MAR 26 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9621

BIRTH NO. _____		REG. DIST. NO. 282		PRIMARY REG. DIST. NO. 4424		Registrar's No. 42	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)			
a. COUNTY Polk		b. CITY (If outside corporate limits, write RURAL and give township) Humansville		a. STATE Missouri		b. COUNTY Polk	
c. LENGTH OF STAY (In this place) 3 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Humansville		d. STREET ADDRESS (If rural, give location)		0840	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Geo. Dimmitt Mem. Hospital							
3. NAME OF DECEASED (Type or Print)		a. (First) Alice		b. (Middle)		c. (Last) Fallis	
4. DATE OF DEATH		(Month) (Day) (Year) 3-15-51.		5. SEX Fe.   W		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 2-6-1861		9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months   Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Bethany Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME William Fallis		13b. MOTHER'S MAIDEN NAME Elmira Jones		14. NAME OF HUSBAND OR WIFE			
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 Mrs Joe Dickinson Dighton, Kans.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4222	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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)		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 2-21, 1951, to 3-15, 1951, that I last saw the deceased alive on 3-15, 1951, and that death occurred at 6:12 P. M., from the causes and on the date stated above.							
23a. SIGNATURE L. G. Robinson D. M.D.				23b. ADDRESS Humansville, Mo		23c. DATE SIGNED 3/16/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-19-51		24c. NAME OF CEMETERY OR CREMATORY Hickory Grove		24d. LOCATION (City, town, or county) (State) Cedar County, Mo.	
DATE REC'D BY LOCAL REG. Mar. 17, 1951		REGISTRAR'S SIGNATURE Ralph Borden per Duell Borden		25. FUNERAL DIRECTOR'S SIGNATURE Primm Funeral Home, Humansville			

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH DEPT. OF MO.  
District No. 5-8

RECEIVED MAR 21 1951

Dist. File 357-282

Date Filed 3-21-51

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 O. H. Beckwith.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 3937.....

P. O. Address Humansville, 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.