

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15476

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 142

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Linn</b>	
b. CITY OR TOWN <b>Kirksville</b>	c. LENGTH OF STAY (in this place) <b>13 WEEKS</b>	c. CITY OR TOWN <b>Bucklin Jwp.</b>	d. STREET ADDRESS (If rural, give location) <b>Rt. #1, 0580</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MCOS Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>SAMUEL</b> b. (Middle) <b>Edween</b> c. (Last) <b>White</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 17, 1951</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>MAR. 18, 1869</b>	9. AGE (in years last birthday) <b>82</b>	if UNDER 1 YEAR Months <b>1</b> Days <b>29</b>	if UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>	11. BIRTHPLACE (State or foreign country) <b>Bucklin Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
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13a. FATHER'S NAME <b>SAMUEL C. White</b>	13b. MOTHER'S MAIDEN NAME <b>MARY A.</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Lehaude C. White</b> ADDRESS <b>Bucklin</b>
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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		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Senility</b>	ANTECEDENT CAUSES	DUE TO (b) <b>Cross Hemipia</b>	<b>2 moos</b>
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <b>Benign Prostatic Hypertrophy</b>	<b>15 yrs</b>	<b>6 wks</b>
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death. <b>Prostatectomy</b>		

19a. DATE OF OPERATION <b>3-28-51</b>	19b. MAJOR FINDINGS OF OPERATION <b>nodules prostate with cystic formation in glandular tissue. cysts contained inflammatory exudate</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? <b>610X</b>
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22. I hereby certify that I attended the deceased from **Feb. 27, 1951** to **May 17, 1951**, that I last saw the deceased alive on **5-17-1951**, and that death occurred at **6:48 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>F. E. Royle</b> (Deceased or title) <b>D.O.</b>	23b. ADDRESS <b>Turkville Mo</b>	23c. DATE SIGNED <b>5-20-51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>MAY 20, 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>WYANDOTTE CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>Bucklin Mo</b>
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DATE REC'D BY LOCAL REG. <b>5-23-51</b>	REGISTRAR'S SIGNATURE <b>Kate Lambert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>O Larson Funeral Service</b> ADDRESS <b>Bucklin Mo.</b>
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WRITE PLAINLY—USING UNFADING, BLACK INK—MAKE A PERMANENT RECORD

10/15  
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MAY 2 1951

Date Received: MAY 28 1951

DISTRICT HEALTH OFFICE #2

District File Number 5-51-10

Date Filed: MAY 29 1951

MAY 29 1951

SEP 1 1951

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: *Donald L. Roberts*

Licensed Embalmer No. *4922*

P. O. Address: *Kimberville*

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.