

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15526

BIRTH NO. _____ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 4024 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Barry	
b. CITY OR TOWN Cassville		c. CITY OR TOWN Cassville 0050	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1101 Main		d. STREET ADDRESS (If rural, give location) 1101 Main 0	
3. NAME OF DECEASED a. (First) Albert b. (Middle) Perry c. (Last) Church			4. DATE OF DEATH (Month) (Day) (Year) 5-1-1951
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3-9-1895
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	11. BIRTHPLACE (State or foreign country) Missouri 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Edgar Church		13b. MOTHER'S MAIDEN NAME Mary Breidert	14. NAME OF HUSBAND OR WIFE Mary Fogg Church
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary Church-Cassville, Missouri
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial degeneration ANTECEDENT CAUSES DUE TO (b) Rheumatoid arthritis DUE TO (c) + Toxicity 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	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) 4222	
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 Jan ; 19: 46 to May , 19 51 , that I last saw the deceased alive on May 1 , 19 51 , and that death occurred at 7 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. A. ...		23b. ADDRESS Cassville, Mo	23c. DATE SIGNED 5-10-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-3-1951	24c. NAME OF CEMETERY OR CREMATORY Corinth Cemetery	24d. LOCATION (City, town, or county) (State) Cassville, Missouri
DATE REC'D BY LOCAL REG. May 10-1951	REGISTRAR'S SIGNATURE Grace Williams	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Miss D. Williams Cassville, Mo	

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

005
1

~~DIVISION OF HEALTH OF MO.
District No. 5 - Springfield~~

~~RECEIVED MAY 14 1951~~

~~Dist. File _____~~

~~Date Filed _____~~

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED MAY 14 1951

Dist. File 131-9132

Date Filed 5-15-51

MAY 22 1951

MAY 21 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 Glenn D. Williams

Licensed Embalmer No. 4651

P. O. Address Cassville 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.