

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16076**
Registrar's No. **31**

FILED MAY 24 1951

BIRTH NO. _____		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 4168		Registrar's No. 31	
1. PLACE OF DEATH a. COUNTY DEKALB				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY DEKALB			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MAYSVILLE-RURAL 54S		c. LENGTH OF STAY (in this place) 5 YRS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maysville-Rural		d. STREET ADDRESS (If rural, give location) 0320	
d. FULL NAME OF HOSPITAL OR INSTITUTION		3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) ELBERT c. (Last) WHITFIELD		4. DATE OF DEATH (Month) (Day) (Year) MAY-25-1951			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JULY 31-1875	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		IF UNDER 15 MIN. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ATHENS ILL.		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME THOMAS WHITFIELD		13b. MOTHER'S MAIDEN NAME DELILA J. TAYLOR		14. NAME OF HUSBAND OR WIFE NELLIE WHITFIELD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Nellie Whitfield ADDRESS Maysville 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 Oct. 1949 , to May 2, 1951 , that I last saw the deceased alive on May 2, 1951 , and that death occurred at 9:00 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) H. H. Caldwell				23b. ADDRESS Maysville Mo		23c. DATE SIGNED 5-5-51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 5-5-51		24c. NAME OF CEMETERY OR CREMATORY OAK LAWN		24d. LOCATION (City, town, or county) (State) MAYSVILLE MO	
DATE REC'D BY LOCAL REG. 5-10-51		REGISTRAR'S SIGNATURE Robert Davidson		320 5. FUNERAL DIRECTOR'S SIGNATURE Chas. Fisher		ADDRESS Funeral Home, Maysville Mo	

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

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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. 3960

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.