

FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24011

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 276 PRIMARY REG. DIST. NO. 5945 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MO b. COUNTY Phelps	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN N Dillon		c. LENGTH OF STAY (In this place) 1 year	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		d. STREET ADDRESS (If rural, give location) Prime N Dillon 8810	
d. FULL NAME OF HOSPITAL OR INSTITUTION Furndale N Home			

3. NAME OF DECEASED (First) (Type or Print) JAMES		b. (Middle) RICH		c. (Last) RICH		4. DATE OF DEATH (Month) (Day) (Year) 7-30-51	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH 1891	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 12 HRS. Hours		11. BIRTHPLACE (State or foreign country) MO	
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? US			

13a. FATHER'S NAME Dont Know		13b. MOTHER'S MAIDEN NAME Dont Know		14. NAME OF HUSBAND OR WIFE none	
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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) m		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Furndale Nursing Home St James Mo	
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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) Epileptic convulsions		II. OTHER SIGNIFICANT CONDITIONS		0	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		5 years	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Epilepsy			
		DUE TO (c)			
		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 3533		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from February 12, 1950, to July 30, 1951, that I last saw the deceased alive on July 19, 1951, and that death occurred at 5:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE C.V. Hammler M.D.		23b. ADDRESS St. James		23c. DATE SIGNED 7-30-51	
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24a. BURIAL, CREMATION REMOVAL (Specify) Burial		24b. DATE 7-30-51		24c. NAME OF CEMETERY OR CREMATORY Dawson Cem		24d. LOCATION (City, town, or county) (State) St James MO	
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DATE REC'D BY LOCAL REG. OFFICE Aug 3-1951		REGISTRAR'S SIGNATURE Cora C. Birmingham		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS De Liekle St James Mo	
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(License of Embalmer's Statement on Reverse Side)

No. 300  
10.48

810  
4

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 \_\_\_\_\_

*Not Embalmed*

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*E. J. Klier*

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.