

FILED DEC 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42311

BIRTH NO. _____ REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 3044 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY Miller			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY MILLER		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ELDON		c. LENGTH OF STAY (in this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ELDON		d. STREET ADDRESS (If rural, give location) 333-W-3rd ST
d. FULL NAME OF HOSPITAL OR INSTITUTION 333-W-3rd ST					

3. NAME OF DECEASED (Type or Print)		a. (First) MARY		b. (Middle) EMMALINE		c. (Last) JEFFRIES		4. DATE OF DEATH (Month) (Day) (Year) Nov 28 1951	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 19 APRIL 1874		9. AGE (In years last birthday) 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife			10b. KIND OF BUSINESS OR INDUSTRY At-Home			11. BIRTHPLACE (State or foreign country) Camden-Co-Mo		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John-O-Huddleston		13b. MOTHER'S MAIDEN NAME Lucy-A-Jeffries		14. NAME OF HUSBAND OR WIFE DERRICK-JEFFRIES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ALTA-McCubans	
				ADDRESS ELDON MO	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia Bronchie					
		ANTECEDENT CAUSES		DUE TO (b) General Senility			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Cardio-Vascular Disease			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) None	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? None	

22. I hereby certify that I attended the deceased from **1948**, to **Nov. 28, 1951**, that I last saw the deceased alive on **Nov. 27, 1951**, and that death occurred at **9:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE M. Allen M.D. (Degree or title)		23b. ADDRESS ELDON MO		23c. DATE SIGNED 30 Nov 51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 30 Nov 51		24c. NAME OF CEMETERY OR CREMATORY New-Hope	
				24d. LOCATION (City, town, or county) (State) Miller-Co Mo	
DATE REC'D BY LOCAL REG. Nov. 30, 1951		REGISTRAR'S SIGNATURE Rosetta Walt		25. FUNERAL DIRECTOR'S SIGNATURE Keith M. Kaye	
				ADDRESS ELDON MO	

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

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RECEIVED
DEC 11 1931
MILLEN BUREAU OF HEALTH
DEPARTMENT

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 *Keith McKays*.....

Licensed Embalmer No. 3998.....

P. O. Address Eldon 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.