

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3714

State File No.

FILED JAN 29 1952

BIRTH NO. _____ REG. DIST. NO. 354 PRIMARY REG. DIST. NO. 4519 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>TEXAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>TEXAS</u>	
b. CITY OR TOWN <u>CABOOL</u>	c. LENGTH OF STAY (in this place) <u>43 gm</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CABOOL</u> <u>1070</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u> b. (Middle) <u>ELWIN</u> c. (Last) <u>DuBois</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 17 52</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>12/20/1856</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>EDWIN DuBois</u>	13b. MOTHER'S MAIDEN NAME <u>MILLARD</u>	14. NAME OF HUSBAND OR WIFE <u>MINNA DuBois</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Ruth Larson</u> ADDRESS <u>CABOOL</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio Sclerotic Heart Disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <u>Senility</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)	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 1946, to Jan 16, 1952, that I last saw the deceased alive on Jan 16, 1952, and that death occurred at 4:20 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Barrett Long</u>	23b. ADDRESS <u>Cabool Mo.</u>	23c. DATE SIGNED <u>Jan 18 1952</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>1-20-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CABOOL CEMET.</u>	24d. LOCATION (City, town, or county) (State) <u>CABOOL MO.</u>
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DATE REC'D BY LOCAL REG. <u>1-18-52</u>	REGISTRAR'S SIGNATURE <u>Gaynell Cunningham</u> <u>3250</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond V. Elliott</u> ADDRESS <u>Cabool</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

070

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

James L. Gentry

Signed.....
Student Embalmer

Licensed Embalmer No. *4718*

P. O. Address *Cabool, 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.