

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4479

4479

FILED FEB 20 1952

BIRTH NO. _____		REG. DIST. NO. 166		PRIMARY REG. DIST. NO. 3018		Registrar's No. 16	
1. PLACE OF DEATH a. COUNTY Dent				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Dent			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem 0331			
d. FULL NAME OF HOSPITAL OR INSTITUTION None W. Salem				d. STREET ADDRESS (If rural, give location) West Salem, 0			
3. NAME OF DECEASED (Type or Print)		a. (First) Simeom		b. (Middle) Sherrit		c. (Last) Bixler	
4. DATE OF DEATH		Feb. 13, 1952		5. SEX M 0		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 14, 1877		9. AGE (In years, last birthday) 74		10. UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Ireland, Indiana /		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Jim Bixler		13b. MOTHER'S MAIDEN NAME Cordelia Miller	
14. NAME OF HUSBAND OR WIFE Mamie Bixler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 488-01-7201		17. INFORMANT'S SIGNATURE OR NAME Fannie Radke, Daughter, Salem, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accidnet 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: 331X Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 8	
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. HOW DID INJURY OCCUR?	
21e. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 1949, 19, to Feb. 13, 19 1952, that I last saw the deceased alive on Feb. 13, 1952 and that death occurred at 8:30 pm from the causes and on the date stated above.		23. SIGNATURE (Degree or title) Joseph P. Smith, D.D. Salem Mo. 2-15-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-15, 1952		24c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery		24d. LOCATION (City, town, or county) (State) Dent County, Mo.	
DATE REC'D BY LOCAL REG. 2-16-52		REGISTRAR'S SIGNATURE M. M. Hart, M.D. by M.E. Johnson & Grantham, Salem, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

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 Marshall C. Blackwell

Licensed Embalmer No. 4713

P. O. Address Salem, ms.

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.