

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12329**

FILED APR 26 1952

BIRTH NO. _____ REG. DIST. NO. **60** PRIMARY REG. DIST. NO. **404** Registrar's No. **10**

1. PLACE OF DEATH a. COUNTY Cedar		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Barton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jerico Springs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN rural Miliora Township	
c. LENGTH OF STAY (In this place) 3 months		d. STREET ADDRESS (If rural, give location) North of Miliora Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bannister Nursing Home			

3. NAME OF DECEASED (Type or Print) a. (First) FRED b. (Middle) _____ c. (Last) THIXTON			4. DATE OF DEATH (Month) (Day) (Year) 3/6/52		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 3/4/1882	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY worked for farmer	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME U. known	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Frank Bannister Jerico spr

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 yrs
	ANTECEDENT CAUSES Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Valvular Heart Disease with General Eburna		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 4214	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) _____	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 **fall 9**, 19**51**, to **March 6**, 19**52**, that I last saw the deceased alive on **Sept 26**, 19**52**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE E. Bannister MD (Degree or title)	23b. ADDRESS Sheldon Mo	23c. DATE SIGNED 3-6-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/8/52	24c. NAME OF CEMETERY OR CREMATORY Sheldon	24d. LOCATION (City, town, or county) (State) Sheldon Mo
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DATE REC'D BY LOCAL REG. 4/10/52	REGISTRAR'S SIGNATURE M. Velma Ellis	25. FUNERAL DIRECTOR'S SIGNATURE Gerald Denny Sheldon Mo	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

200
4

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

S. Grace Deeny

Signed.....

Student Embalmer

Licensed Embalmer No. *4503*

P. O. Address: *Sheldon, 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.