V.S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24874

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 5588 Registrar's No. 140

0491

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

1. PLACE OF DEATH
a. COUNTY Jasper
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural / Sarcoxie Twp
c. LENGTH OF STAY (in this place) Lyr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R F D / Sarcoxie Mo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Jasper
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural / Sarcoxie Twp
d. STREET ADDRESS (If rural, give location) Sarcoxie RI Mo

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) Whitaker c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) 7-22-52

5. SEX fe
6. COLOR OR RACE wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH 3-21-1882
9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (City and State or Foreign Country) Osage Co, Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Andre Luys
13b. MOTHER'S MAIDEN NAME unknown
14. NAME OF HUSBAND OR WIFE W. J. Whitaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT'S SIGNATURE OR NAME Mrs Tom Grace ADDRESS Sarcoxie 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary Instantaneous

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4261
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1951, *to* July 23, 1952, *that I last saw the deceased alive on* 16 July, 1952, *and that death occurred at* 6 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) H E Byrd M D
23b. ADDRESS Carthage, Mo
23c. DATE SIGNED 7/23/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-26-52
24c. NAME OF CEMETERY OR CREMATORY Harvey Cem
24d. LOCATION (City, town, or county) (State) La Russell Mo

DATE REC'D BY LOCAL REG. 7-25-52
REGISTRAR'S SIGNATURE L B Clinton 139 MD
25. FUNERAL DIRECTOR'S SIGNATURE Jackson & Sons ADDRESS Sarcoxie Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 7-31-52
Jasper County Health Office
County File Number 52/2/005
Date Filed 8-2-52

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 me

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Sarcoxie 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.