

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5661

24999
State File No.

FILED JUL 22 1952

BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 4283 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY LEWIS		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MISSOURI b. COUNTY LEWIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Durham, Lewis Co. Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MAYWOOD, MO Rural	
c. LENGTH OF STAY (In this place) 1 yr		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Fredrick	c. (Last) WITHERS	4. DATE OF DEATH (Month) (Day) (Year) JULY 16 1952
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5. SEX MALE	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 20 1872	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING	10b. KIND OF BUSINESS OR INDUSTRY GENERAL	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME ERNEST WITHERS	13b. MOTHER'S MAIDEN NAME LIZZIE GARKIE	14. NAME OF HUSBAND OR WIFE ZELLA WITHERS
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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. —	17. INFORMANT'S SIGNATURE OR NAME Zella Withers	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anoxemia	DUE TO (b) Coronary Thrombosis		20 yrs.
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Embolus		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arterio-Sclerosis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	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) (Min.)	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 **3 July, 1952**, to **16 July, 1952**, that I last saw the deceased alive on **16 July, 1952**, and that death occurred at **8:14 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Wills D.O. 2	23b. ADDRESS Lewis town, MO.	23c. DATE SIGNED 17 July
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24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE JULY 18 1952	24c. NAME OF CEMETERY OR CREMATORY DURHAM	24d. LOCATION (City, town, or county) (State) M. DURHAM, MO.
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DATE REC'D BY LOCAL REG. 7-19-52	REGISTRAR'S SIGNATURE P.W. Jennings M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Ball	ADDRESS Ewing, MO.
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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 _____

Lewis Martin Crabill

working under my personal supervision.

Student Embalmer No. *450*

Signed *Thomas Ball*

Signed *Lewis Martin Crabill*

Student Embalmer.

Licensed Embalmer No. *1744*

P. O. Address *Ewing, 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.