S. No. 300
v. 10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30919

State File No.

FILED OCT 6 1952

BIRTH NO. REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 326

1. PLACE OF DEATH
a. COUNTY State Hospital No 1
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Calloway Fulton Mo
c. LENGTH OF STAY (In this place) 18 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Pettis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sedalia 1309 W. Main
d. STREET ADDRESS (If rural, give location) 0804 1

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

4. DATE OF DEATH (Month) (Day) (Year) October 1, 1952

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0
8. DATE OF BIRTH June 19, 1874
9. AGE (In years last birthday) 78 — If under 1 year: Months 3, Days 12 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and State or Foreign Country) Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Lewis Christian
13b. MOTHER'S MAIDEN NAME Mary Jane Vaught
14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) D.K. (If yes, give war or dates of service) D.K.
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME State Hospital #1, Fulton, Mo. ADDRESS

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) Cardiac Asthma

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic Myocarditis.

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 None
19b. MAJOR FINDINGS OF OPERATION 4222
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No
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) None 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* Sept-15, 1952, *to* Oct-1-, 1952, *that I last saw the deceased alive on* 0 Sept-, 1930, *and that death occurred at* 7:25 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE J. E. Caldwell MD (Degree or title)
23b. ADDRESS Fulton Mo
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 3-1952
24c. NAME OF CEMETERY OR CREMATORY DK.
24d. LOCATION (City, town, or county) Sedalia (State) Mo

DATE REC'D BY LOCAL REG. Oct-1-1952
REGISTRAR'S SIGNATURE Maretta Lawrence 426-
25. FUNERAL DIRECTOR'S SIGNATURE Duane Ewing, Sedalia, Mo. 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 R. E. Baker

Licensed Embalmer No. 2419

P. O. Address Sedalia, 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.