

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **39763**

FILED DEC 11 1952

BIRTH NO. _____ REG. DIST. NO. **282** PRIMARY REG. DIST. NO. **4424** Registrar's No. **137**

1840
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Polk		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Humansville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Humansville	
c. LENGTH OF STAY (in this place) 1 week		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Geo. Dimmitt Mem. Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Julia b. (Middle) Ann c. (Last) Ball			4. DATE OF DEATH (Month) (Day) (Year) Nov. 28, 1952		
5. SEX Fe		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 11/21/1889			9. AGE (In years) 63		10. MONTHS 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Savannah, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Charlton Wilcox		13b. MOTHER'S MAIDEN NAME Julia Jump		14. NAME OF HUSBAND OR WIFE Charley W.	
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 Charley W. Ball, Humansville, Mo.	

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) Chronic Myocarditis		II. OTHER SIGNIFICANT CONDITIONS. Hypertension			?
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Chronic nephritis Type Unilateral			
		DUE TO (c)			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION. 592X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 18, 1952, to November 19, 1952, that I last saw the deceased alive on 11/28, 1952, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE J. J. Robinson (Degree or title) M.D.		23b. ADDRESS Humansville, Mo.		23c. DATE SIGNED 11/28/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/30/52		24c. NAME OF CEMETERY OR CREMATORY Humansville Cemetery	
24d. LOCATION (City, town, or county) (State) Humansville, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Beckwith Funeral Home, Humansville			
DATE REC'D BY LOCAL REG. 12-5, 1952		REGISTRAR'S SIGNATURE Ralph Gardner		25. FUNERAL DIRECTOR'S ADDRESS	

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 O. H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Humansville 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.