U.S. No. 300
Rev. 10-48

FILED JAN 15 1953

STANDARD CERTIFICATE OF DEATH

State File No. 638

BIRTH NO. _____ REG. DIST. NO. 66 PRIMARY REG. DIST. NO. 4117 Registrar's No. _____

0210
1

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

1. PLACE OF DEATH
a. COUNTY: Chariton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rothville
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Chariton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rothville 0210
d. STREET ADDRESS (If rural, give location): 0

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

4. DATE OF DEATH (Month) (Day) (Year): 1 — 8 — 53

5. SEX: M 0

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 11-16-1870

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months 1, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Labor

11. BIRTHPLACE (State or foreign country): Missouri 0

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Steven Daniel

13b. MOTHER'S MAIDEN NAME: Unknow

14. NAME OF HUSBAND OR WIFE: Deceased

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 Bernice Crispin — ADDRESS: Mendon 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): Coronary Thrombosis, Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c): Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: 4201

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* April, 1953 *to* 1-8, 1953 *that I last saw the deceased alive on* 1-7, 1953 *and that death occurred at* 3:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert W. Smith MD 0

23b. ADDRESS: Monceline, Mo

23c. DATE SIGNED: 1-10-53

24a. BURIAL, CREMATION REMOVAL (Specify): Burial

24b. DATE: 1-10-53

24c. NAME OF CEMETERY OR CREMATORY: McCullough

24d. LOCATION (City, town, or county) (State): Triphett MO

DATE REC'D BY LOCAL REG.: 1-14-53

REGISTRAR'S SIGNATURE: Maud Wright 0 450

25. FUNERAL DIRECTOR'S SIGNATURE: S. L. Leipard — ADDRESS: Mendon Mo

(Licensed Embalmer's Statement on Reverse Side)

JAN 28 1953

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 L. L. Leipard

Licensed Embalmer No. 3970

P. O. Address Mendon 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.