

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2401**

FILED JAN 26 1953

REG. DIST. NO. **264**

PRIMARY REG. DIST. NO. **5-885**

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Ozark		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Ozark	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willhoit Barren Township		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willhoit Rural	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION J		d. STREET ADDRESS (If rural, give location) J	
3. NAME OF DECEASED (Type or Print) a. (First) Lee b. (Middle) High c. (Last) High		4. DATE OF DEATH (Month) 1 (Day) 12 (Year) 53	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12 29 1880
9. AGE (In years last birthday) 72		10. 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) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John High	
13b. MOTHER'S MAIDEN NAME Fannie Allen		14. NAME OF HUSBAND OR WIFE Dovey High	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Lee High		ADDRESS Willhoit	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 6 mo ANTECEDENT CAUSES 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
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)		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 Nov. 15, 1952 , to 1-12, 1953 , that I last saw the deceased alive on 1-12, 1953 , and that death occurred at 2 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE M. J. Holman, D.D. (Degree or title)		23b. ADDRESS Gainesville, Mo.	
23c. DATE SIGNED 1-15-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-14-53	
24c. NAME OF CEMETERY OR CREMATORY Loftis Cemetery		24d. LOCATION (City, town, or county) (State) Willhoit rural Mo.	
DATE REC'D BY LOCAL REG. 1-24-53		25. FUNERAL DIRECTOR'S SIGNATURE Thas Mahan ADDRESS Clinkingbeard Funeral Home Gainesville	

(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

John B. Hersey

Licensed Embalmer No. 4885

P. O. Address. Quinnville, Me.

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.