No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8467

LED FEB 25 1953

BIRTH NO. _____ REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 3075 Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY: Stoddard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dexter
c. LENGTH OF STAY (in this place): 1 yr
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: Missouri
b. COUNTY: Stoddard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dexter 1031
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Samuel
c. (Last): Givens

4. DATE OF DEATH (Month) (Day) (Year): Feb. 11, 1953

5. SEX: male 0
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 29, 1884
9. AGE (In years last birthday): 68
If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

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

13a. FATHER'S NAME: Joe Givens
13b. MOTHER'S MAIDEN NAME: Mary Ann Brown
14. NAME OF HUSBAND OR WIFE: Zona Givens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): X X
16. SOCIAL SECURITY NO.: X X
17. INFORMANT'S SIGNATURE OR NAME: Zona Givens
ADDRESS: Dexter, 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): Typhoid Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Hemorrhage — 5 days
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: 331 X
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* Feb 1, 1953, *to* Feb 11, 1953, *that I last saw the deceased alive on* Feb 11, 1953, *and that death occurred at* 6 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Dexter Mo
23c. DATE SIGNED: 2/18/53

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 2-13-53
24c. NAME OF CEMETERY OR CREMATORY: Dexter cemetery
24d. LOCATION (City, town, or county) (State): Dexter, Mo.

DATE REC'D BY LOCAL REG.: 2-18-53
REGISTRAR'S SIGNATURE: [signature] 4047
25. FUNERAL DIRECTOR'S SIGNATURE: Watkins Funeral Ser.
ADDRESS: Dexter, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Walter Marsh Watkins

Licensed Embalmer No. 4717

P. O. Address [illegible] 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.