

FILED APR 14 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9054

State File No. 5175-#069

BIRTH NO. _____ REG. DIST. NO. 49 PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY CAMDEN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Camden	
b. CITY (If outside corporate limits, write BURAL and give township) OR TOWN MAKES CREEK		c. CITY (If outside corporate limits, write BURAL and give township) OR TOWN Makes Creek. 0150	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) CHARLES CHESTER ELDRED			4. DATE OF DEATH (Month) (Day) (Year) 3-29-1953		
a. (First)	b. (Middle)	c. (Last)	5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 9-22-1885	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 1 YEAR Hours 0 Min. 0	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Small
11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA	13a. FATHER'S NAME Clifford Eldred	13b. MOTHER'S MAIDEN NAME Katharine Logan	14. NAME OF HUSBAND OR WIFE Bertha	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs Bertha Eldred	ADDRESS Makes Creek Mo	18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) None	MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asthmatic Heart	INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Mitral Insufficiency	19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION 4342
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 1 day only , 19 53 ; that I last saw the deceased alive on 3-29 , 19 53 , and that death occurred at Makes Creek from the causes and on the date stated above.	23a. SIGNATURE E. L. [Signature] (Degree or title) 0	23b. ADDRESS M. D. (Camden) Mo.	23c. DATE SIGNED 4-2-53	24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3-31-1953	24c. NAME OF CEMETERY OR CREMATORY Makes Creek	24d. LOCATION (City, town, or county) (State) Makes Creek Mo	DATE REC'D BY LOCAL REG. 4-3-1953	REGISTRAR'S SIGNATURE Alda R. Eldred	25. FUNERAL DIRECTOR'S SIGNATURE R B Jones ADDRESS Buffalo Mo

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

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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Mani B Jones

Signed.....
Student Embalmer

Licensed Embalmer No. *4322*

P. O. Address *Bull Run, Va.*

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.