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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 21 1953

State File No. 15242

BIRTH NO. _____ REG. DIST. NO. 176 PRIMARY REG. DIST. NO. 5945 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY: Phelps
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St James - Rural n. E.
c. LENGTH OF STAY (In this place): 1 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ferndale Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Butler
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bernie, Mo 0070
d. STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print)
a. (First): KATie
b. (Middle): SWATzeLL
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Apr. 11-1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb 7, 1879
9. AGE (In years last birthday): 74
If under 1 year: Months: 2 Days: 4
If under 24 hrs.: Hours: Min.:

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): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Dauk Knaw
13b. MOTHER'S MAIDEN NAME: Dauk Knaw
14. NAME OF HUSBAND OR WIFE: Dauk Knaw

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 ADDRESS: Ferndale Nursing Home - St James 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) Pneumonia — Interval between onset and death: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) following Influenza — 7 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: 480 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* 3-12, 1953 *to* April 11, 1953 *that I last saw the deceased alive on* 4-9, 1953, *and that death occurred at* 10:200 m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. Hammler (Degree or title): M.D.
23b. ADDRESS: St. James Mo.
23c. DATE SIGNED: 4-13-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Apr. 14, 1953
24c. NAME OF CEMETERY OR CREMATORY: Bernie Cemetery
24d. LOCATION (City, town, or county) (State): Bernie, Mo.

DATE REC'D BY LOCAL REG.: 4-13-53
REGISTRAR'S SIGNATURE: Ruth B. Powell 479
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Oral E. Lickliter - St James 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 ..... Me ..... Student Embalmer No. ..... working under my personal supervision.

Student .....
Student Embalmer

Signed Orell E. Lickliter

Licensed Embalmer No. 3546

P. O. Address 9 Jenny 2

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.