

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20494**

FILED MAY 25 1953

BIRTH NO. _____		REG. DIST. NO. 354		PRIMARY REG. DIST. NO. 4579		Registrar's No. 535	
1. PLACE OF DEATH a. COUNTY TEXAS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY TEXAS			
b. CITY (If outside corporate limits, write RURAL and give township) CABOOL		c. LENGTH OF STAY (In this place) 509 w.		c. CITY (If outside corporate limits, write RURAL and give township) CABOOL, MO. 1070			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print) a. (First) LAKE		b. (Middle) ANDERSON		c. (Last) DOVE		4. DATE OF DEATH (Month) (Day) (Year) MAY 12-53	
5. SEX M	6. COLOR OR RACE W	7. MARRIED: NEVER MARRIED; WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JUNE 29-1899	9. AGE (In years) last birthday 53	if UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CABOOL, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME A.N. DOVE		13b. MOTHER'S MAIDEN NAME unk		14. NAME OF HUSBAND OR WIFE LILLIE DOVE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillie Dove, Cabool			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Valvular Heart Disease SECONDARY DUE TO (c) MEDICAL TREATMENT II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 mos. 10 years.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4214				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) (Min.)		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 Dec , 1952, to May 11, 1953 , that I last saw the deceased alive on May 11, 1953 , and that death occurred at 5:00 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Gaynell Cunningham				23b. ADDRESS Cabool Mo		23c. DATE SIGNED May 19/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 5/19/53		24c. NAME OF CEMETERY OR CREMATORY CABOOL CEMET.		24d. LOCATION (City, town, or county) (State) CABOOL MO.	
DATE REC'D BY LOCAL REG. 5-14-53		REGISTRAR'S SIGNATURE Gaynell Cunningham		25. FUNERAL DIRECTOR'S SIGNATURE James F. Stealy		ADDRESS Cabool	

(Licensed Embalmer's Statement on Reverse Side)

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

070
1

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.....
Student Embalmer

Signed *James L. Gentry*
Licensed Embalmer No. *4718*

P. O. Address *Cabool, 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.