

S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24318

539 State File No. 2

FILED AUG 10 1953

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>3-018</u>		Registrar's No. <u>62</u>	
1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>			
b. CITY OR TOWN <u>Watkins rural</u>		c. LENGTH OF STAY (in this place) <u>yr's</u>		c. CITY OR TOWN <u>Lenox</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <u>Watkins typ</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lou</u>		b. (Middle) <u>Alzer</u>		c. (Last) <u>Headrick</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7/31/53</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>6/26/1872</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? _____							
13a. FATHER'S NAME <u>John Dodd Turner</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Jimson</u>			14. NAME OF HUSBAND OR WIFE <u>G W Headrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John C Headrick Jack Mo</u>			
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) <u>Hypostatic Pneumonia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Fracture left femur</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) <u>033</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		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 <u>7/26</u> 19 <u>53</u> , to <u>7/31</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7/30</u> , 19 <u>53</u> , and that death occurred at <u>4:55A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joy C Mitchell M.D.</u>				23b. ADDRESS <u>Salem, Mo.</u>		23c. DATE SIGNED <u>8/1/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>8/1/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Herman Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Salem Mo</u>	
DATE REC'D BY LOCAL REG. <u>8/8/53</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

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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.....
Signature of Student Embalmer

Signed Not Embalmed

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.