

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **25516**

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

BIRTH NO. _____ REG. DIST. NO. **L76** PRIMARY REG. DIST. NO. **565-2** Registrar's No. **22**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY Lorraine	b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Miller Lincoln	a. STATE Missouri	b. COUNTY Lorraine
c. LENGTH OF STAY (in this place) 12 yr.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Miller Lincoln	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dye Rest Home		d. STREET ADDRESS (If rural, give location) 0550	

3. NAME OF DECEASED (Type or Print)	a. (First) Montzelle	b. (Middle)	c. (Last) McChain	4. DATE OF DEATH (Month) (Day) (Year) 7-10-1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 7-10-1863	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months 0 Days 2	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Greene Co. Mo.	12. CITIZEN OF WHAT COUNTRY? Native
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13a. FATHER'S NAME R. T. Johns	13b. MOTHER'S MAIDEN NAME Sarah Wallis	14. NAME OF HUSBAND OR WIFE
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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. None	17. INFORMANT'S SIGNATURE OR NAME Dr. W. S. Burney	ADDRESS Miller Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bleed ulcers		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Septicemia DUE TO (c) Chronic Nephritis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None noted			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 592X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 1, 1953, to 7-10, 1953, that I last saw the deceased alive on 7-10, 1953, and that death occurred at 1a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. S. Burney M.D.	23b. ADDRESS Miller Mo.	23c. DATE SIGNED 7-16-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-14-1953	24c. NAME OF CEMETERY OR CREMATORY Johns Chapel	24d. LOCATION (City, town, or county) (State) S. of Ash Grove Mo.
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DATE REC'D BY LOCAL REG. 7-18-53	REGISTRAR'S SIGNATURE W. S. Burney	25. FUNERAL DIRECTOR'S SIGNATURE Morris Lumar	ADDRESS Miller Mo.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student)
Student Embalmer

Signed _____

E. R. Lemian

Licensed Embalmer No. 3297

P. O. Address Miller 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.