

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25611**
Registrar's No. **85**

FILED **JUL 24 1953** REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **3041**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) Macon		c. CITY (If outside corporate limits, write RURAL and give township) Beverly Mo 061P	
c. LENGTH OF STAY (In this place) 5 days		d. STREET ADDRESS (If rural, give location) Rt 2 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Shawnee Hosp.			

3. NAME OF DECEASED a. (First) LOYAL b. (Middle) ERVIN c. (Last) NORTH			4. DATE OF DEATH (Month) (Day) (Year) 7-8-53		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 4-5-26		9. AGE (In years last birthday) 27		10. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Minnesota	

13a. FATHER'S NAME Eric North		13b. MOTHER'S MAIDEN NAME Jane Putman		14. NAME OF HUSBAND OR WIFE Edith North	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 49-74-0822A		17. INFORMANT'S SIGNATURE OR NAME Edith North ADDRESS Beverly 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Kidney insufficiency - Uremia			INTERVAL BETWEEN ONSET AND DEATH 1 mo.
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carbuncles - infection			2 wks
		DUE TO (c) Anemia - severe			1 year
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. general septic condition Meningitis			1 wk.
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION 293X			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 **25 June, 1953**, to **7 July, 1953**, that I last saw the deceased alive on **July 7, 1953**, and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Donald E. Eggleston M.D.		23b. ADDRESS Macon, Missouri		23c. DATE SIGNED 13 July 53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-10-53		24c. NAME OF CEMETERY OR CREMATORY Jimtown Cem.		24d. LOCATION (City, town, or county) (State) Queen City 770	
DATE REC'D BY LOCAL REG. 7/14/53		REGISTRAR'S SIGNATURE Ruth McNeely		25. FUNERAL DIRECTOR'S SIGNATURE H. E. Edwards		ADDRESS Beverly Mo	

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

0.300
0.48

FEB 8 1953

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RECEIVED
MAGON COUNTY HEALTH DEPARTMENT
7-20-53
County File No. 7-52-126
Date Filed 7-22-53

31. 30 1953

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 *H. E. Edwards*

Licensed Embalmer No. *1961*

P. O. Address *Bevier 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.