

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

State File No. **27458**

FILED **AUG 12 1953**

BIRTH NO. _____ REG. DIST. NO. **347** PRIMARY REG. DIST. NO. **6165** Registrar's No. **36**

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

1. PLACE OF DEATH a. COUNTY Stone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN "Rural" Hurley		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN "Rural" Hurley	
c. LENGTH OF STAY (In this place) 43 Yrs.			
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) Route 2, Crane	
3. NAME OF DECEASED (Type or Print) a. (First) Eva b. (Middle) May c. (Last) HERNDON			4. DATE OF DEATH (Month) (Day) (Year) July 22-1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 8-1884
9. AGE (In years last birthday) 68		10. MONTHS 7	11. DAYS 14
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 (State or foreign country) Springfield, Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Henry Painter		13b. MOTHER'S MAIDEN NAME Frances Elizabeth Hudson	14. NAME OF HUSBAND OR WIFE Frank Herndon
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 Leonard Herndon, Rt. 2, Crane, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) medullary failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) medullary thrombosis DUE TO (c) arteriosclerosis 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 No 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) 4500	
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 8-16 , 19 53 , to 7-22 , 19 53 , that I last saw the deceased alive on 7-12 , 19 53 , and that death occurred at 1:15pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Herald Shaffer D.D.		23b. ADDRESS Nixa, Missouri	23c. DATE SIGNED 7-29-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 24-'53	24c. NAME OF CEMETERY OR CREMATORY Jamesville Cemetery	24d. LOCATION (City, town, or county) (State) Jamesville, Missouri
DATE REC'D BY LOCAL REG. aug. 1-53	REGISTRAR'S SIGNATURE Mr. J. Elmer Brodeur	25. FUNERAL DIRECTOR'S SIGNATURE John Dean Harris ADDRESS Clever, Mo.	

Per Anna Murray (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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John Alan Harris

Licensed Embalmer No. 4390

P. O. Address Clever, 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.