

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34891**

FILED NOV 5 - 1953

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **346**

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) Kirksville	c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville 0013 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1415-N-FRANKLIN		d. STREET ADDRESS (If rural, give location) 711 W. Porter	

3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) ----- c. (Last) Logston			4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1953		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 2, 1884	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	11. BIRTHPLACE (State or foreign country) Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME David Logston		13b. MOTHER'S MAIDEN NAME Amy Mullanix		14. NAME OF HUSBAND OR WIFE Maude Logston	
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. 487-14-7360		17. INFORMANT'S SIGNATURE OR NAME Maude Logston, Kirksville, Mo.	
17. ADDRESS 711 W. Porter					

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			INTERVAL BETWEEN ONSET AND DEATH Wks
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Asthma (Functional)		ANTECEDENT CAUSES DUE TO (b) Asthma 4 or 5 years			
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 241X		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)	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 10-23- **1953, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:12 a.m., from the causes and on the date stated above.**

23a. SIGNATURE Robert B. Davis 3 Coroner		23b. ADDRESS Kirksville Adair Co. Mo.	23c. DATE SIGNED 10-23-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 26, 1953	24c. NAME OF CEMETERY OR CREMATORY Rose Cemetery	24d. LOCATION (City, town, or county) (State) Putnam Co., Mo.

DATE REC'D BY LOCAL REG. 10-26-53	REGISTRAR'S SIGNATURE Kate Lambert 1-0	25. FUNERAL DIRECTOR'S SIGNATURE Glenn E. Felt 1-0	ADDRESS Green City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed

Karl B. Kent

Licensed Embalmer No.

4689

P. O. Address

Gren City, N.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.