

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36890**

FILED OCT 29 1953

BIRTH NO. _____ REG. DIST. NO. **298** PRIMARY REG. DIST. NO. **6023** Registrar's No. **12**

0890

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

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) Rural Knoxville		c. LENGTH OF STAY (in this place) 25 yrs	
c. CITY (If outside corporate limits, write RURAL and give township) Rural Knoxville		d. STREET ADDRESS (If rural, give location) 0890 6 miles east of Lawson	
d. FULL NAME OF HOSPITAL OR INSTITUTION		3. NAME OF DECEASED a. (First) SUSAN b. (Middle) FRANCES c. (Last) DANIEL	
4. DATE OF DEATH (Month) (Day) (Year) Oct. 20 1953		5. SEX Female 6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct. 12 1865	
9. AGE (In years last birthday) 88 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) 0 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME John Henry Fields		13b. MOTHER'S MAIDEN NAME Catherine Bates	
14. NAME OF HUSBAND OR WIFE Calvin Co. Mo.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, no. or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Chester Daniel Lawson Mo ADDRESS _____	
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) Chronic Myocarditis (b) Ca of Sigmoid Colon (c) Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. 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) Lawson (COUNTY) Ray (STATE) Mo		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 _____, 19 50 , to Oct 18 , 19 53 , that I last saw the deceased alive on Oct 18 , 19 53 and that death occurred at 8 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Octave Buehler (Degree or title) M.D.		23b. ADDRESS Lawson Mo	
23c. DATE SIGNED 10/22/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Oct 22 '53		24c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
24d. LOCATION (City, town, or county) Ray Co (State) Mo		25. FUNERAL DIRECTOR'S SIGNATURE Garman Oriskand ADDRESS Lawson Mo	
DATE REC'D BY LOCAL REG. Oct 22, 1953		REGISTRAR'S SIGNATURE Mrs Raymond Grove	

OCT 29 1958

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 Linnell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Spring 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.