

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

39495

State File No. \_\_\_\_\_

FILED DEC 10 1953

S. No. 300  
v. 10.48

BIRTH NO. _____		REG. DIST. NO. <u>157</u>		PRIMARY REG. DIST. NO. <u>3028</u>		Registrar's No. <u>246</u>	
1. PLACE OF DEATH a. COUNTY <u>JASPER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>JASPER</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>CARTHAGE</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>CARTHAGE</u>		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>422 COOPER ST.</u>				e. STREET ADDRESS (If rural, give location) <u>422 COOPER ST.</u> 0430			
3. NAME OF DECEASED a. (First) <u>SAMUEL</u> (Type or Print)			b. (Middle) <u>LEROY</u>		c. (Last) <u>ZANE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 2 1953</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 16, 1861</u>		9. AGE (In years last birthday) <u>92</u>	if UNDER 1 YEAR Months _____ Days _____	if UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired mail carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>MENARD CO. ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>JAMES S. ZANE</u>		13b. MOTHER'S MAIDEN NAME <u>RACHAEL PURVIANCE</u>		14. NAME OF HUSBAND OR WIFE <u>MARYBELLE ZANE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ALICE GLADDEN 422 COOPER</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>GUNSHOT WOUND HEAD FATAL</u>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>E976X</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>SUICIDE</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>BARN AT HOME</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>CARTHAGE JASPER MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/2/53 3:30P</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>HEAD PISTOL TO HEAD BEHIND RT. EAR BULLET ENTERED SKULL PENETRATING BRAIN</u>			
22. I hereby certify that I attended the deceased from <u>(DIED, NOT, I ATTEND)</u> , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>newelbert md former Jasper Co</u>				23b. ADDRESS <u>Jasper Mt Bldg Jasper Mo</u>		23c. DATE SIGNED <u>12-3-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12/5/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>PARK CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>CARTHAGE, MO.</u>		
DATE REC'D BY LOCAL REG. <u>12-4-53</u>		REGISTRAR'S SIGNATURE <u>Lloyd B. Clinton MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>KNELL MORTUARY, CARTHAGE, MO.</u>			

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

RECEIVED DEC 8 1953  
Jasper County Health Office  
County File Number 23-12-984  
Date Filed DEC 9 1953

MAR 17 1954

DEC 22 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.....  
Signature of Student Embalmer

Signed..... Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.