

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42193**

XC-UNKNOWN
RN-5693
ED JAN 7 1954

REG. DIST. NO. **43**

PRIMARY REG. DIST. NO. **3007**

Registrar's No. **59**

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MISSOURI COUNTY CAPE GIRARDEAU CO.	
b. CITY (If outside corporate limits, write RURAL and give town OR POPLAR BLUFF township)		c. CITY (If outside corporate limits, write RURAL and give township) OR CAPE GIRARDEAU	
c. LENGTH OF STAY (in this place) 1 DAY		d. STREET ADDRESS (If rural, give location) 0164 /	
d. FULL NAME OF HOSPITAL OR INSTITUTION VA HOSPITAL			

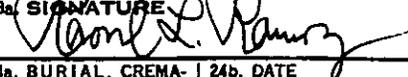
3. NAME OF DECEASED a. (First) CHARLES (Type or Print)			b. (Middle) E.			c. (Last) DARK			4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 26, 1953						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH DECEMBER 11, 1926			9. AGE (In years last birthday) 27		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY TRUCKING CO.				11. BIRTHPLACE (State or foreign country) CHARLESTON, MO.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			

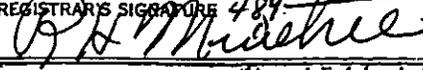
13a. FATHER'S NAME LUTHER S. DARK			13b. MOTHER'S MAIDEN NAME CLAUDIA B. MEATTE			14. NAME OF HUSBAND OR WIFE WILMA DARK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 490-24-5904			17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS			ADDRESS		

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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LACERATION OF BRAIN WITH SEVERE		GENERAL EDEMA.						38 HRS	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO FRACTURE SKULL MIDDLE CRANIAL FOSSA							
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>									

19a. DATE OF OPERATION 12-26-53		19b. MAJOR FINDINGS OF OPERATION SEVERE EDEMA OF BRAIN						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hy. 55 in Scott Co.		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Mo. Charleston, rural Scott, Mo.					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12 -24 -53 10:30 PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Auto turned over on S curve near Charleston					

22. I hereby certify that I attended the deceased from **12-25-53**, 19___, to **12-26-53**, 19___, and that death occurred at **11:37a m.**, from the causes and on the date stated above.

23a. SIGNATURE 		(Degree or title) M.D.		23b. ADDRESS VA HOSPITAL POPLAR BLUFF, MO.		23c. DATE SIGNED 12-26-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/28/53		24c. NAME OF CEMETERY OR CREMATORY I.O.O.F		24d. LOCATION (City, town, or county) (State) Charleston, Mo.	

DATE REC'D BY LOCAL REG. 12/30/53		REGISTRAR'S SIGNATURE 		25. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS THE MINNELEE FUNERAL CHAPEL, Charleston, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

JAN 5 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

JAN 7 1954

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 F. [Signature]*
Licensed Embalmer No. 3857
P. O. Address Charleston, 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.