

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44889**

FILED JAN 12 1954
279nd

BIRTH NO. _____ REG. DIST. NO. **340** PRIMARY REG. DIST. NO. **4503** Registrar's No. **11**

10320

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

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bernie		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bernie	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Corday c. (Last) DeGournett			4. DATE OF DEATH (Month) (Day) (Year) 12 22 53		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 12-19-1923	9. AGE (In years last birthday)	IF UNDER 1 YEAR (Days) (Hours) (Min.) 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME William DeGournett	13b. MOTHER'S MAIDEN NAME Peggy Sue Carley	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME William DeGournett	ADDRESS Bernie
--	-------------------------------------	---	-----------------------

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus Spina Bifida (Herniating meninges)		
	ANTECEDENT CAUSES Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____		
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	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 **12-19-1953**, to **12-22-1953**, that I last saw the deceased alive on **12-21-1953**, and that death occurred at **4:42 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. J. Edmundson M.D.	23b. ADDRESS Malden, Missouri	23c. DATE SIGNED 12-24-53
--	--------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-28-53	24c. NAME OF CEMETERY OR CREMATORY Bernie Cemetery	24d. LOCATION (City, town, or county) (State) Bernie Mo
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. 1-5-54	REGISTRAR'S SIGNATURE Helena V. Jenkins	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Bernie
--	--	---	-----------------------

(Licensed Embalmers' Statements 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 _____

Body not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

[Handwritten Signature]

Licensed Embalmer No. _____

[Handwritten Signature]

P. O. Address _____

Bennie

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.