

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45015

State File No.

69248
FILED JAN 18 1954

BIRTH NO.: _____ REG. DIST. NO. 86 PRIMARY REG. DIST. NO. 5323 Registrar's No. 29-1953

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Knobview Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Knobview Twp.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>10 Miles NW of Cuba</u>		d. STREET ADDRESS (If rural, give location) <u>10 miles N.W. of Cuba</u>	
3. NAME OF DECEASED a. (First) <u>Albert</u> b. (Middle) <u>Leslie</u> c. (Last) <u>Souders</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 - 11 - 1953</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>Sept. 18, 1953</u>
9. AGE (In years last birthday) <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>**</u>	11. BIRTHPLACE (State or foreign country) <u>Cuba, Mo., Route 0</u>
13a. FATHER'S NAME <u>James F. Souders</u>		13b. MOTHER'S MAIDEN NAME <u>Arlene Jacobson</u>	14. NAME OF HUSBAND OR WIFE <u>**</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>James F. Souders Cuba, Mo. Rt.</u>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>typhoid</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>acute Gastroenteritis</u> 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 " _____ <u>5710</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>SEPT. 18, 1953</u> , to <u>12-11, 1953</u> , that I last saw the deceased alive on <u>12/9, 1953</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Signer or title) <u>John Elders M.D.</u>		23b. ADDRESS <u>Cuba, Mo.</u>	
23c. DATE SIGNED <u>12/11/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-12-1953</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Licklider Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>near Cuba; Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-12-1953</u>		REGISTRAR'S SIGNATURE <u>James P. ... 372</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Malford H. ...</u>		ADDRESS <u>OWENSVILLE Mo.</u>	

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

0280

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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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Maury H. H. Hunter

Licensed Embalmer No. 3838

P. O. Address OWENSVILLE

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.