

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 69

0040
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FILED FEB 3 1954

BIRTH NO. _____ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 5037 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY. <u>Audrain</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RFD. SALT RIVER</u>		c. LENGTH OF STAY (In this place) <u>10 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mexico</u>		<u>RD 4B</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Neill Rest Home</u>			d. STREET ADDRESS (If rural, give location) <u>1121 N. Jefferson</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Antwine</u> b. (Middle) <u>Reynold</u> c. (Last) <u>Womack</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 29, 1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 3, 1877</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 12 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fire Brick Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Callaway Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Jacob Womack</u>		13b. MOTHER'S MAIDEN NAME <u>Malicia Altheiser</u>	14. NAME OF HUSBAND OR WIFE <u>Stella May Womack</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>88</u>		16. SOCIAL SECURITY NO. <u>491-24-0864</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Onie Robertson</u> ADDRESS <u>Mexico, Mo.</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>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Nephritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>4 yrs</u> <u>6 mo.</u>
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 <u>Nov. 14, 1952</u> , to <u>Jan 29, 1954</u> , that I last saw the deceased alive on <u>Jan 28, 1954</u> , and that death occurred at <u>5:21am.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>John A. Owens, D.O.</u>			23b. ADDRESS <u>Mexico, Mo.</u>		23c. DATE SIGNED <u>1-29-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 31, 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Santa Fe Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Santa Fe, Missouri.</u>		
DATE REC'D BY LOCAL REG. <u>JAN 30-1954</u>	REGISTRAR'S SIGNATURE <u>Blanche Neely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Cross</u>		ADDRESS <u>Mexico Mo.</u>

RECEIVED
JAN 10 1913

STATEMENT BY LICENSED EMBALMER

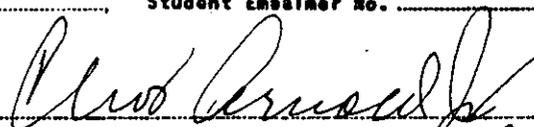
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 3569

P. O. Address Myico 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.