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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2492

State File No.

28847
FILED JAN 21 1954

REG. DIST. NO. 214 PRIMARY REG. DIST. NO. 4459 Registrar's No. 5

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

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri St. Clair Hickory	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Quincy	
d. FULL NAME OF HOSPITAL OR INSTITUTION Todd's Hospital		d. STREET ADDRESS (If rural, give location) Hickory County	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Arley c. (Last) Harper			4. DATE OF DEATH (Month) (Day) (Year) Jan; 15 1954		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH May 27, 1953	9. AGE (In years last birthday) IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) 77 19	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Wheatland Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME A.H. Harper		13b. MOTHER'S MAIDEN NAME Ethel Feaster		14. NAME OF HUSBAND OR WIFE ---	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS A.H. Feaster, Quincy Missouri		
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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		INTERVAL BETWEEN ONSET AND DEATH 24 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		
	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 493X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 1-14, 1954, to 3:50 PM 1-15, 1954, that I last saw the deceased alive on 1-15, 1954, and that death occurred at 3:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Frank Judd, M.D.	23b. ADDRESS Osceola, Mo.	23c. DATE SIGNED 1-15-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-16-54	24c. NAME OF CEMETERY OR CREMATORY Iconium	24d. LOCATION (City, town, or county) (State) Iconium Missouri
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DATE REC'D BY LOCAL REG. 1-15-54	REGISTRAR'S SIGNATURE Ethel Feaster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Feaster, Osceola Mo
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(Licensed Embalmer's Statement 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

J. B. [Signature]

Licensed Embalmer No.

3038

P. O. Address

Osceola, 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.