

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3699**

FILED JAN 8 1954

BIRTH NO. _____		REG. DIST. NO. <u>388</u>		PRIMARY REG. DIST. NO. <u>4510</u>		Registrar's No. <u>14</u>		
1. PLACE OF DEATH a. COUNTY <u>Sullivan Co 1050</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Osgood</u>		c. LENGTH OF STAY (In this place) <u>6-yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Osgood</u>		1050		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>O</u>				
3. NAME OF DECEASED (Type or Print) <u>JAMES EARLS DEARING</u>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <u>Jan 2 1954</u>		(Month) (Day) (Year)		5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>4-18-1876</u>		9. AGE (In years last birthday) <u>77</u>		# UNDER 1 YEAR Months Days		
9. AGE (In years last birthday) <u>77</u>		# UNDER 1 YEAR Months Days		# UNDER 24 HRS. Hours Mins.		10. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) <u>Retired Farmer</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Sullivan Co Mo O</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Broyles Dearing</u>		13b. MOTHER'S MAIDEN NAME <u>Adeline Regan</u>		14. NAME OF HUSBAND OR WIFE <u>Grace Dearing</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Grace Dearing Osgood Mo</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS				
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>				INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>		
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</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>331X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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>1-1-1953</u> , to <u>1-2-1953</u> , that I last saw the deceased alive on <u>12-31-1953</u> , and that death occurred at <u>1:00 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>H. C. Weston M.D.</u>				23b. ADDRESS <u>Galt Mo</u>		23c. DATE SIGNED <u>1-2-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>1-3-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Osborn Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Harris Mo</u>		
DATE REC'D BY LOCAL REG. <u>Jan 6</u>		REGISTRAR'S SIGNATURE <u>Greta Caldwell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>RK Payne Son</u>		ADDRESS <u>Galt Mo</u>		

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

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Salt

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.