

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11445**

FILED MAY 5 1954

BIRTH NO.		REG. DIST. NO. 02		PRIMARY REG. DIST. NO. 5182		Registrar's No. 31	
1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau			
b. CITY (If outside corporate limits, write RURAL and give township) Rural Shawano		c. LENGTH OF STAY (In this place) 3 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) Rural		0160	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3 miles S. Neely Landing				d. STREET ADDRESS (If rural, give location) 3 mi S. Neely Landing Mo.			
3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL b. (Middle) — c. (Last) ATCHISON			4. DATE OF DEATH (Month) (Day) (Year) April 26 - 1954				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH Dec 5, 1885	
9. AGE (In years last birthday) 68		10a. USUAL OCCUPATION (Give kind of work done during years of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Neely Landing Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Jacob Atchison		13b. MOTHER'S MAIDEN NAME Louise Brock		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Willes Truff Cape Girardeau Mo.			
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) unknown found detailed in lab					INTERVAL BETWEEN ONSET AND DEATH
II. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 7953				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 the morning of _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE D. G. Lisher Registrar				23b. ADDRESS Jackson Mo.		23c. DATE SIGNED April 28, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 28, 1954		24c. NAME OF CEMETERY OR CREMATORY Old McAndrew		24d. LOCATION (City, town, or county) (State) near Jackson Mo.	
DATE REC'D BY LOCAL REG Apr 28 1954		REGISTRAR'S SIGNATURE D. G. Lisher +3-C		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Miller Jackson Mo.			

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 Gene C. Crawford

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.