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FILED MAY 11 1954

## STANDARD CERTIFICATE OF DEATH

State File No. 12915

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 275 PRIMARY REG. DIST. NO. 3053 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rolla	c. LENGTH OF STAY (in this place) 3 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rolla 0812	
d. FULL NAME OF HOSPITAL OR INSTITUTION McFarland Nursing Home		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) May b. (Middle) Della c. (Last) Atkinson	4. DATE OF DEATH (Month) (Day) (Year) April 22 54
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 9, 1870	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 11 Days 13	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Franklin Co., Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME W.M. Jones	13b. MOTHER'S MAIDEN NAME Catherine	14. NAME OF HUSBAND OR WIFE James Atkinson
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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 None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. E.H. Wolff	ADDRESS 7 Spring Drive Florissant, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma.			
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of face 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	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) 191X
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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 Jan 24, 1954, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on Jan 24, 1954, and that death occurred at 3:40A m., from the causes and on the date stated above.

23a. SIGNATURE Dorothy R. Stoll	(Degree or title)	23b. ADDRESS Rolla Mo	23c. DATE SIGNED May 5 1954
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 24, 54	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) St. James, Missouri
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DATE REC'D BY LOCAL REG. May 5, 1954	REGISTRAR'S SIGNATURE Dorothy R. Stoll	380	25. FUNERAL DIRECTOR'S SIGNATURE C. Jesse Lake	ADDRESS Ph. James
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(Licensed Embalmer's Statement on Reverse Side)

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

County File Number

Date Filed

5-10-57

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

working under my personal supervision.

Student Embalmer No.

Signed

*C. Jesse Gahr*

Signed Student Embalmer

Licensed Embalmer No. 4486

P. O. Address St. James, 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.