

FILED JUN 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18543

BIRTH NO. _____ REG. DIST. NO. 120 PRIMARY REG. DIST. NO. 5444 Registrar's No. 57

380

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

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Township A</u> c. LENGTH OF STAY (in this place) <u>1 yr.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Athens Township</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Plainview Rest Home</u>		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>Lewis</u>	c. (Last) <u>Justice</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 11 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 23 1861</u>	9. AGE (In years last birthday) <u>92</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u>	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) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Davies Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>H.H. Justice</u>	13b. MOTHER'S MAIDEN NAME <u>Fern Sperry</u>	14. NAME OF HUSBAND OR WIFE <u>Barbara McGuire</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. C.N. Roberson</u> ADDRESS <u>St. Joseph Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</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. <u>Chronic Asthma</u>		10 yrs.	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.) _____	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 2, 1954, to June 10, 1954, that I last saw the deceased alive on June 10, 1954, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. J. Pray, D.O.</u>	23b. ADDRESS <u>Albany, Mo.</u>	23c. DATE SIGNED <u>6-12-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 13-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mc Fall Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Mc Fall, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>June 14 54</u>	REGISTRAR'S SIGNATURE <u>Maudie Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford Brooks</u> ADDRESS <u>Albany Mo.</u>
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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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Letitia Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.