

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23658

State File No.

No. 300

10.48

BIRTH NO. _____		REG. DIST. NO. <u>207</u>		PRIMARY REG. DIST. NO. <u>5753</u>		Registrar's No. <u>29</u>	
1. PLACE OF DEATH a. COUNTY <u>Maries</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Maries</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Meta Rt. 1</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Meta Rt. 1.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>His Home</u>				e. STREET ADDRESS (If rural, give location) <u>Boone Twp.</u> <u>0630</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) <u>Thomas</u> c. (Last) <u>Kellison</u>			4. DATE OF DEATH (Month) <u>7</u> (Day) <u>26</u> (Year) <u>54</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-29-70</u>		9. AGE (In years Last birthday) <u>83</u>	IF UNDER 1 YEAR Month <u>9</u> Days <u>27</u>	IF UNDER 4 HRS. Hour _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Kellison</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine Kellison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Wade Kellison</u> ADDRESS <u>Meta Rt. 1</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemiplegia</u> ANTECEDENT CAUSES DUE TO (b) <u>Vascular hypertension, Arteriosclerosis, Un-</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>known.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) <u>3/34x</u>			
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>July 19</u> , 19 <u>54</u> , to <u>July 26</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>July 26</u> , 19 <u>54</u> and that death occurred at <u>7.40P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Wade Kellison</u> (Degree or title) <u>D.O. 2</u>			23b. ADDRESS <u>Dixon, Mo.</u>			23c. DATE SIGNED <u>7-28-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/28/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeler Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Maries Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>7-30-54</u>		REGISTRAR'S SIGNATURE <u>Pauline Howard</u>		FURNERIAL DIRECTOR'S SIGNATURE <u>W. P. Cunningham</u>		ADDRESS <u>Vienna, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 27 1954

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.....
Signature of Student Embalmer

Signed: *M. B. Cunningham*

Licensed Embalmer No. *36*

P. O. Address *Memphis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.