No. 300
10-48

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23996

State File No.

BIRTH NO. REG. DIST. NO. 278 PRIMARY REG. DIST. NO 3054 Registrar's No. 78

1. PLACE OF DEATH
a. COUNTY Pike
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Louisiana
c. LENGTH OF STAY (In this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pike Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Mo
b. COUNTY Pike
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Frankford
d. STREET ADDRESS (If rural, give location) 0 820 0

3. NAME OF DECEASED (Type or Print)
a. (First) Charles
b. (Middle) W
c. (Last) Uzell

4. DATE OF DEATH (Month) July (Day) 8 (Year) 1954

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Oct 26 1867
9. AGE (In years last birthday) 86 | If under 1 year: Months 8 Days 19 | If under 1 hr.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St Louis Co Mo
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME James R. Uzell
13b. MOTHER'S MAIDEN NAME Nancy Rose
14. NAME OF HUSBAND OR WIFE Susan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Mrs. McClellan Kirkwood 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia & Enteritis — INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) Colitis - Dehydration — 1 week
~~DUE TO~~ (c) Hypertensive Cardio vascular Disease — yrs.

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 443X
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6, 1954, *to* 7-8, 1954 *that I last saw the deceased alive on* 7-7, 1954 *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Chas H Lewellen (Degree or title) M.D.
23b. ADDRESS Louisiana Mo
23c. DATE SIGNED 7/15/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 9 1954
24c. NAME OF CEMETERY OR CREMATORY Bowling Green
24d. LOCATION (City, town, or county) Bowling Green (State) Mo

DATE REC'D BY LOCAL REG. July 15, 1954
REGISTRAR'S SIGNATURE Bernice Collier
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Grace Lankford Bowling Green

(Licensed Embalmer's Statement on Reverse Side)

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 Harold Kirks

Licensed Embalmer No. Bowling Gre

P. O. Address 4597

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.