

FILED AUG 10 1954

STANDARD CERTIFICATE OF DEATH

State File No. 24185

BIRTH NO. 124		REG. DIST. NO. 316		PRIMARY REG. DIST. NO. 6075		Registrar's No. 230	
1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Francois			
b. CITY OR TOWN St. Francois - Rural		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Farmington		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pratts Nursing Home				e. STREET ADDRESS (If rural, give location) 094/0			
3. NAME OF DECEASED (Type or Print) Theodocia Logsdon			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH July 30 1954	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Sept 2 1870		9. AGE (In years last birthday) 83	10. MONTHS 10	11. DAYS 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hospital attendant # 4			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles Sanderw		13b. MOTHER'S MAIDEN NAME Irene MERRICK		14. NAME OF HUSBAND OR WIFE J. M. Logsdon (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Irene Ogle Farmington 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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 3 days	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular disease.						
	DUE TO (c) Generalized arteriosclerosis						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443X						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) m.		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 9-1 1953, to 7-30, 1954, that I last saw the deceased alive on 7-29, 1954, and that death occurred at 12:10 P.M., from the causes and on the date stated above.							
23a. SIGNATURE C. E. Conleton M.D.				23b. ADDRESS Farmington Mo		23c. DATE SIGNED 7-31-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 1 1954	24c. NAME OF CEMETERY OR CREMATORY Parkview Cem.		24d. LOCATION (City, town, or county) Farmington Mo		(State)	
DATE REC'D BY LOCAL REG. July 31, 1954	REGISTRAR'S SIGNATURE Esther Rudloff			25. FUNERAL DIRECTOR'S SIGNATURE Cozean, Farmington Mo			

(Licensed Embalmers' 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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 408

P. O. Address Farmington

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.