

34402

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 18 1954

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. <u>160</u>		PRIMARY REG. DIST. NO. <u>5592</u>		Registrar's No. <u>88</u>		
1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Madison</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Festus., Mo R # 1</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Saco</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <u>R. F. D. # 1</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emanuel</u> b. (Middle) <u>Leo</u> c. (Last) <u>Womack</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 2, 1954</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 5, 1910</u>		9. AGE (In years last birthday) <u>43/11/27</u>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Filling Station Attendant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Sta.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Womack, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Millie Womack</u>		14. NAME OF HUSBAND OR WIFE <u>Irene Darnell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-05-2773</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James Darnell, Fredricktown Mo. R # 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cornary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Heart Failure</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	
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>1/2 mi So. of Festus Jeff. Mo</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>Feld on August 10-3-54</u> , 19 <u>54</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>W. B. Edwards, M.D. Coroner</u>				23b. ADDRESS <u>Order Hill Mo</u>		23c. DATE SIGNED <u>10/3/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/5/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fredricktown, Mo.</u>			
DATE RECD BY LOCAL REG. <u>10-4-54</u>		REGISTRAR'S SIGNATURE <u>James C. [Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Adams and Webb</u>		ADDRESS <u>Fredricktown, Mo</u>		

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

(Licensed Embalmer's Statement on Reverse Side)

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

OCT 14 1954

OCT 14 1954

OCT 14 1954

OCT 19 1954

OCT 20 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.....

Licensed Embalmer No. 4244

P. O. Address. Capital City

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.