

FILED NOV 15 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34528

BIRTH NO. 71094-54 REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 445

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Brookfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>1024 N. Main Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Dena</u> b. (Middle) <u>DeCanniere</u> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 27, 1954</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NM</u>	8. DATE OF BIRTH <u>October 27, 1954</u>
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Brookfield, Mo.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>	
13a. FATHER'S NAME <u>Albert DeCanniere</u>		14. NAME OF HUSBAND OR WIFE	
13b. MOTHER'S MAIDEN NAME <u>Viola Matthes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>A. H. DeCanniere, Brookfield, Mo.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital atelectasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
ANTECEDENT CAUSES DUE TO (b) <u>Prematurity (6 mos)</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:  DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Multiple areas of ecchymosis due to increased capillary fragility</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>7625</u>	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) (Min)	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>10-27</u> , <u>1954</u> , to <u>10-27</u> , <u>1954</u> , that I last saw the deceased alive on <u>10-27</u> , <u>1954</u> , and that death occurred at <u>7:00p</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>John R. Dyer, M.D.</u> (Degree or title)		23b. ADDRESS <u>Brookfield, Mo.</u>	23c. DATE SIGNED <u>10-29-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 28, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u>
DATE REC'D BY LOCAL REG. <u>10-30-54</u>	REGISTRAR'S SIGNATURE <u>Madeline Stambach</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>	

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.

*Not embalmed*

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.