

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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

BIRTH NO. _____ REG. DIST. NO. 311 PRIMARY REG. DIST. NO. 4436 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) Appleton City	c. LENGTH OF STAY (in this place) 2 months	c. CITY (If outside corporate limits, write RURAL and give township) Appleton City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Eliott Memorial Hospital		d. STREET ADDRESS (If rural, give location) Rural Route # 3	

3. NAME OF DECEASED (Type or Print) a. (First) David b. (Middle) B. c. (Last) Withrow	4. DATE OF DEATH (Month) (Day) (Year) Nov. 26 - 1954
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 21 - 1872	9. AGE (In years last birthday) Months Days 82 3 5	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Withrow	13b. MOTHER'S MAIDEN NAME Sarah Williams	14. NAME OF HUSBAND OR WIFE unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 450-03-7865	17. INFORMANT'S SIGNATURE OR NAME Lena O'Rear, Appleton City, Mo.	ADDRESS Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic C.V. disease		yo
	DUE TO (c)		
	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 4221	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 **10-8-54**, 19___, to **11-26-54**, 19___, that I last saw the deceased alive on **11-26-54**, 19___, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. H. Slickman, MD	23b. ADDRESS Appleton City, Mo.	23c. DATE SIGNED Nov 27 54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 28 - 1954	24c. NAME OF CEMETERY OR CREMATORY Salem Cemetery	24d. LOCATION (City, town, or county) (State) Foster, Mo.
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DATE REC'D BY LOCAL REG. Nov. 27, 1954	REGISTRAR'S SIGNATURE Oles Obrey 285-0	25. FUNERAL DIRECTOR'S SIGNATURE Melvin L. Samsone	ADDRESS Appleton City
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Melvin L. Janssens*
Licensed Embalmer No. *4529*

P. O. Address *Appleton City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.