

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 1 - 1955

State File No. **2125**

BIRTH NO. _____ REG. DIST. NO. **294** PRIMARY REG. DIST. NO. **305** Registrar's No. **27**

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly		c. CITY OR TOWN Moberly	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 533 Ha good		STREET ADDRESS (If rural, give location) 533 Ha good	

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) _____ c. (Last) Cash			4. DATE OF DEATH (Month) (Day) (Year) Jan 17-1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 7 - 1871	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 10 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd TIVERY STABLE EMPLOYE.		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Mo	

13a. FATHER'S NAME James Cash	13b. MOTHER'S MAIDEN NAME Delaney Vaughn	14. NAME OF HUSBAND OR WIFE UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs Okie Todd ADDRESS Moberly, 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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 da
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 _____	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) Moberly Randolph Mo
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 **Jan 16, 1955**, to **Jan 17, 1955**, that I last saw the deceased alive on **Jan 16, 1955**, and that death occurred at **5:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Smith M.D.	23b. ADDRESS Moberly, Mo.	23c. DATE SIGNED 1-19-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-19-55	24c. NAME OF CEMETERY OR CREMATORY Keytesville	24d. LOCATION (City, town, or county) (State) Keytesville, Mo
DATE REC'D BY LOCAL REG. 1-19-55	REGISTRAR'S SIGNATURE Leah Hoover	25. FUNERAL DIRECTOR'S SIGNATURE Mahan and Son ADDRESS Moberly, Mo	

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.....
Frank D. Witt

Licensed Embalmer No. *3021*

P. O. Address *Moberly*

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.