

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5683

FILED FEB 21 1955

State File No. _____

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|--|----------------------------------|---|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY Nodaway | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Missouri b. COUNTY Worth | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville | | c. LENGTH OF STAY (In this place) 9 weeks | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan | | 1130 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital | | | | d. STREET ADDRESS (If rural, give location) (None) | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) John | | b. (Middle) C. | | c. (Last) White | |
| 4. DATE OF DEATH | | (Month) January | | (Day) 31, | | (Year) 1955 | |
| 5. SEX Male <input type="radio"/> | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Oct. 21, 1866 | 9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Hired Tenant | | 11. BIRTHPLACE (City and State or Foreign Country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13a. FATHER'S NAME John White | | 13b. MOTHER'S MAIDEN NAME (Unknown) | | 14. NAME OF HUSBAND OR WIFE Eliza Niece White | | | |
| 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. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marie Thummel - Parnell, Missouri | | | |
| 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) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Intertrochanteric fracture of Rt femur 3.31X4 | | | | INTERVAL BETWEEN ONSET AND DEATH 3 or more ? | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Intertrochanteric fracture Rt femur | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Carewading, Worth, MO | | 21f. HOW DID INJURY OCCUR? fall | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from Dec. 4, 1954 , to Jan. 31, 1955 , that I last saw the deceased alive on January 3, 1955 , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) D. S. Pylant M.D. | | | | 23b. ADDRESS Maryville, Mo | | 23c. DATE SIGNED 3/5/55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Feb. 2, 1955 | | 24c. NAME OF CEMETERY OR CREMATORY Isadora Cemetery | | 24d. LOCATION (City, town, or county) (State) Isadora, Missouri | |
| DATE REC'D BY LOCAL REG. 2-19-55 | | REGISTRAR'S SIGNATURE Bess Hult | | 25. FUNERAL DIRECTOR'S SIGNATURE Bill G. Dunfee | | ADDRESS Frank City, 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

Student Embalmer

Signed Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address Frank City, Mo.

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.