

FILED APR 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10925

State File No.

BIRTH NO. _____ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 4024 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Barry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cassville	c. LENGTH OF STAY (in this place) 26 yrs.	c. CITY OR TOWN Cassville	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 504 West Street		e. STREET ADDRESS (If rural, give location) 504 West Street	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Marguerite	b. (Middle) Mae	c. (Last) Daniels	(Month) 4	(Day) 14	(Year) 55

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-9-1901	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months 8 Days 16	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	----------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Store Clerk	10b. KIND OF BUSINESS OR INDUSTRY Variety Store	11. BIRTHPLACE (City and State or Foreign Country) Creston, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME William H. Lyon	13b. MOTHER'S MAIDEN NAME Winnie Mae Klehn	14. NAME OF HUSBAND OR WIFE Chester Daniels
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Chester Daniels	ADDRESS Cassville, 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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bunshot wound of brain	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Depressive psychosis		Instantaneous
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			6 mos.

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) Suicide	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 Oct., 1953, to Apr. 14, 1955, that I last saw the deceased alive on _____, 19____, and that death occurred between 10:00 a.m. and 11:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Mary Newman	(Degree or title) M. S.	23b. ADDRESS Cassville, Mo.	23c. DATE SIGNED 4-15-55
-----------------------------------	--------------------------------	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-16-55	24c. NAME OF CEMETERY OR CREMATORY Rogers Cemetery	24d. LOCATION (City, town, or county) (State) Rogers Ark.
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. 4-15-55	REGISTRAR'S SIGNATURE Mary McDonald	25. FUNERAL DIRECTOR'S SIGNATURE W. Williams	ADDRESS Cassville, Mo.
---	--	---	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

0050

0050

BARRY COUNTY HEALTH UNIT
CASSVILLE, MO.

NO. 455-231

DATE REC. 4-16-55

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 Phyllis E. Williamson

Licensed Embalmer No. 488

P. O. Address Cassville

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.