

FILED JUN 15 1955

STANDARD CERTIFICATE OF DEATH

State File No. 16299

BIRTH NO. _____		REG. DIST. NO. 294		PRIMARY REG. DIST. NO. 3056		Registrar's No. 140	
1. PLACE OF DEATH a. COUNTY Randolph				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Chariton			
b. CITY (If outside corporate limits, write RURAL and give township) TOWN Moberly		c. LENGTH OF STAY (in this place) 2-Days		c. CITY (If outside corporate limits, write RURAL and give township) TOWN Keytesville		210	
d. FULL NAME OF HOSPITAL OR INSTITUTION Woodland Hospital				d. STREET ADDRESS (If rural, give location) 408 Cleveland Ave.			
3. NAME OF DECEASED (Type or Print) Dempsey		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH		June 2nd, 1955		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 24th, 1892		9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	
11. BIRTHPLACE (State or foreign country) Keytesville, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME O.B. Anderson		13b. MOTHER'S MAIDEN NAME Julia Scott	
14. NAME OF HUSBAND OR WIFE Nannie Anderson		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. 440-05-5209		17. INFORMANT'S SIGNATURE OR NAME Mrs. Nannie Anderson	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic coronary thrombosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 7 days 7 day	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4201	
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) m.		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 June 1, 1955, to June 2, 1955, that I last saw the deceased alive on June 1, 1955, and that death occurred at 3:20 A.M., from the causes and on the date stated above.							
23a. SIGNATURE Charles Clohrs M.D.				23b. ADDRESS Moberly, Mo.		23c. DATE SIGNED June 3-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 4th, 1955		24c. NAME OF CEMETERY OR CREMATORY City Cemetery		24d. LOCATION (City, town, or county) (State) Keytesville, Mo.	
DATE REC'D BY LOCAL REG. 6-4-55		REGISTRAR'S SIGNATURE Calvin Lowe 269-0		25. FUNERAL DIRECTOR'S SIGNATURE Keytesville, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 20 1956

JAN 15 1956

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.....

H. D. Garrett

Signed.....
Student Embalmer

Licensed Embalmer No. *3046*

P. O. Address. *Key West, Fla.*

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.