

FILED JUN 17 1955

THE DIVISION OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18155

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 468 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Mo, b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maysville	c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maysville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home in town		d. STREET ADDRESS (If rural, give location) 0320 0	

3. NAME OF DECEASED (Type or Print)		a. (First) George		b. (Middle) William		c. (Last) Truex		4. DATE OF DEATH (Month) (Day) (Year) 5 - 3 - 55		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 3. 1884		9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days		IF UNDER 28 HRS. Hours Mts.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.				

13a. FATHER'S NAME George Truex		13b. MOTHER'S MAIDEN NAME Martha Case		14. NAME OF HUSBAND OR WIFE Allie Truex	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No, CXXXXXXXXXXXX		16. SOCIAL SECURITY NO. XXXXXXXXXXXX		17. INFORMANT'S SIGNATURE OR NAME Allie Truex	
				ADDRESS Maysville 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma of Prostate and urinary bladder</i> 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.		INTERVAL BETWEEN ONSET AND DEATH ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
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 August 17, 1947, to May 3, 1955, that I last saw the deceased alive on 5/3, 1955, and that death occurred at 8:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE <i>W. Harold Fowler</i>		(Degree or title)		23b. ADDRESS Maysville Mo		23c. DATE SIGNED 5/4/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-5-55		24c. NAME OF CEMETERY OR CREMATORY Shambaugh		24d. LOCATION (City, town, or county) (State) Weatherby Mo,	

DATE REC'D BY LOCAL REG. 6-15-55		REGISTRAR'S SIGNATURE <i>Roscoe Durbin</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John Brown</i>		ADDRESS Maysville Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

1955 YEARBI - 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John Brown

Signed.....
Student Embalmer

Licensed Embalmer No.....

3933

P. O. Address.....

Maysville 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.