

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21967

State File No. ....

FILED JUL 18 1955

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>39</u>			
1. PLACE OF DEATH a. COUNTY <u>Howe</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (In this place) <u>1 yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fremont, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>184</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Hogan</u>				d. STREET ADDRESS (If rural, give location)					
3. NAME OF DECEASED (Type or Print) a. (First) <u>De Lacy J.</u> b. (Middle) <u>Desch</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>6-19-55</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>2</u>		8. DATE OF BIRTH <u>4-3-1892</u>			
9. AGE (In years less birthday) <u>63</u>		10. MONTHS <u>2</u>		11. DAYS <u>17</u>		12. HOURS <u>1</u> MIN. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Goodland, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Matthew Adams</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Farrell</u>		14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME (Address) <u>E. Desch, Fremont, Mo</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CONGESTIVE HEART FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>				DUE TO (c) <u>HYPERTENSION, ESSENTIAL</u>				DUE TO (c) <u>UNKNOWN</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>BRONCHIAL PNEUMONIA C</u>				RECOVERY <u>331x</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) _____		21d. (COUNTY) _____		21e. (STATE) _____		21f. HOW DID INJURY OCCUR? _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>6-11-55</u> to <u>6-19, 1955</u> , that I last saw the deceased alive on <u>6-19, 1955</u> , and that death occurred at <u>7:15</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Jack N. Wilson, M.D.</u>			23b. ADDRESS <u>West Plains, Mo.</u>			23c. DATE SIGNED <u>6-25-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>9-22-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wilderness</u>		24d. LOCATION (City, town, or county) (State) <u>Wilderness, Mo</u>			
DATE REC'D BY LOCAL REG. <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		379		25. FUNERAL DIRECTOR'S SIGNATURE (Address) <u>Robertson West Plains, Mo</u>			

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

*A. S. Roberts*

Licensed Embalmer No. *3427*

P. O. Address *West Plains, 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.