

FILED AUG 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22738

State File No. _____

No. 300

10. 48

BIRTH NO. _____		REG. DIST. NO. <u>174</u>	PRIMARY REG. DIST. NO. <u>5644</u>	Registrar's No. <u>69</u>
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Lexington Twns.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Lexington Twns.</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3 miles South of Lexington</u>		d. STREET ADDRESS (If rural, give location) <u>3 Mi. South of Lexington</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>		b. (Middle) <u>Henry</u>		c. (Last) <u>George</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, <u>2</u> WIDOWER, DIVORCED (Specify)
8. DATE OF BIRTH <u>March 15, 1867</u>		9. AGE (In years, last birthday) <u>88</u>		IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Oak Grove, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed.</u>		
13a. FATHER'S NAME <u>John George</u>		13b. MOTHER'S MAIDEN NAME <u>Lavina White</u>		14. NAME OF HUSBAND OR WIFE <u>None deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Sam. B. Smith, Lexington, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) <u>Short illness, no physician had seen him for approx. one year</u> DUE TO (c) <u>No evidence of violence</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>No surgery</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>No</u>		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) _____ (Min.) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WORK <input type="checkbox"/> WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>birth</u> to <u>27</u> , 19 <u>55</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>27</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>W. W. Mark</u>		23b. ADDRESS <u>1000 Olive St.</u>		23c. DATE SIGNED <u>7-27-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 29, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>
24d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>8-1-55</u>		REGISTRAR'S SIGNATURE <u>M. W. Sparks</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Odesa, Mo.</u>

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

(Licensed Embalmer's Statement on Reverse Side)

AUG 1 1968 T T 8114

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: William T. Sparks

Signed:
Student Embalmer

Licensed Embalmer No. 4431

P. O. Address. Odessa, AM

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.