

FILED AUG 2 - 1955

STANDARD CERTIFICATE OF DEATH

State File No. **22910**

BIRTH NO. _____ REG. DIST. NO. **210** PRIMARY REG. DIST. NO. **5776** Registrar's No. **51**

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

0640

1. PLACE OF DEATH a. COUNTY MERCER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY MERCER	
b. CITY (If outside corporate limits, write RURAL and give township) MILL GROVE	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN MILL GROVE	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 Washla Hosp.		e. STREET ADDRESS (If rural, give location) Washington trap	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) EDWARD c. (Last) MARKS			4. DATE OF DEATH (Month) (Day) (Year) JULY 23 1955					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 16 1876	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME WILLIAM MARKS		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE ELLESIVE MARKS	
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.		17. INFORMANT'S SIGNATURE OR NAME ELLESIVE MARKS ADDRESS MILL GROVE 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bright disease		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 592 X	
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 **June 1, 1955**, to **July 23, 1955**, that I last saw the deceased alive on **July 22, 1955**, and that death occurred at **4:00 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE J. M. Perry M.D. (Degree or title)		23b. ADDRESS Pinetown MO		23c. DATE SIGNED July 23-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JULY 26 1955		24c. NAME OF CEMETERY OR CREMATORY MILL GROVE CEM.		24d. LOCATION (City, town, or county) (State) MILL GROVE MO.	
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DATE REC'D BY LOCAL REG. 7-27-55		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE SCHOKER FUNERAL HOME ADDRESS SPICKARD MO.	
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Cross Wise*

Licensed Embalmer No. *277*

P. O. Address *Spickard*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.