

FILED AUG 4 - 1955

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23165**

BIRTH NO.		REG. DIST. NO. 275		PRIMARY REG. DIST. NO. 3053		Registrar's No. 141	
1. PLACE OF DEATH a. COUNTY Phelps				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dent			
b. CITY (If outside corporate limits, write RURAL and give township) Rolfah		c. LENGTH OF STAY (In this place) 1 day		c. CITY OR TOWN Salem		d. Is 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 Phelps Co. Memorial				e. STREET ADDRESS (If rural, give location) xx			
3. NAME OF DECEASED (Type or Print) a. (First) Joseph		b. (Middle) Milton		c. (Last) Mounce		4. DATE OF DEATH (Month) (Day) (Year) 7-26-55	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov 29 1890	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and State or Foreign Country) Dent Co Mo	
12. CITIZEN OF WHAT COUNTRY? U S		13a. FATHER'S NAME John Mounce		13b. MOTHER'S MAIDEN NAME Fannie Hall		14. NAME OF HUSBAND OR WIFE Della Trail	
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. 497-10-8050		17. INFORMANT'S SIGNATURE OR NAME Della Mounce Salem 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic atherosclerosis DUE TO (c) Heart Disease & Hypertension				INTERVAL BETWEEN ONSET AND DEATH 36 Hours	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X				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)			
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 7-26-55 to 7-26-55 , that I last saw the deceased alive on 7-26-55 , and that death occurred at 2:20 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Wm. C. ...				23b. ADDRESS Della Mo		23c. DATE SIGNED 7/27/55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-28-55		24c. NAME OF CEMETERY OR CREMATORY Stagner Cem		24d. LOCATION (City, town, or county) (State) Dent Co Mo	
DATE REC'D BY LOCAL REG. July 27, 1955		REGISTRAR'S SIGNATURE Nadine L. Stoll		25. FUNERAL DIRECTOR'S SIGNATURE Carl H. ...		ADDRESS Salem Mo	

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

RECEIVED

Phelps County Health Officer,

County File Number _____

Date Filed Aug 2 1955

~~Aug 8~~

AUG 18 1955

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 _____
Signature of Student Embalmer

Signed Carl H. Spencer

Licensed Embalmer No. 237

P. O. Address Salina

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.