

No. 300
10.48

FILED AUG 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25438**
Registrar's No. **469**

BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fisk	
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hosp.		d. STREET ADDRESS (If rural, give location) Fisk	

3. NAME OF DECEASED (Type or Print) a. (First) Harley b. (Middle) Oscar c. (Last) Combs			4. DATE OF DEATH (Month) (Day) (Year) August 17 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-4-1893	9. AGE (In years last birthday) 62	10. IF UNDER 1 YEAR Months 6 Days 13
10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Fredrick Town Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Pete Combs		13b. MOTHER'S MAIDEN NAME Mary White		14. NAME OF HUSBAND OR WIFE Loria Combs	
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 Loria Combs	
				ADDRESS Fisk, 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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		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) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 9/17		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 002X	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 **8-9**, 19**55**, to **8-17**, 19**55**, that I last saw the deceased alive on **8-17**, 19**55** and that death occurred at **12:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. M. W. ...		23b. ADDRESS Poplar Bluff, Mo.	23c. DATE SIGNED 8-17-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-19-55	24c. NAME OF CEMETERY OR CREMATORY Shain Memorial	24d. LOCATION (City, town, or county) (State) Butler, Co. Mo.

DATE REC'D BY LOCAL REG. 8/23/55	REGISTRAR'S SIGNATURE Ph. Mueller	25. FUNERAL DIRECTOR'S SIGNATURE J.C. ...	ADDRESS Fisk, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

AUG 29 1955

BUTLER CO. HEALTH CENTER

FILE No. _____

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 Raymond L. Duffin

Licensed Embalmer No. 4798

P. O. Address Bernie, 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.