

FILED AUG 30 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25712**

BIRTH NO. _____		REG. DIST. NO. <b>99</b>		PRIMARY REG. DIST. NO. <b>5373</b>		Registrar's No. <b>12</b>			
1. PLACE OF DEATH a. COUNTY <b>DeKalb</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>DeKalb</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maysville</b>		c. LENGTH OF STAY (in this place) <b>Life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maysville</b>		d. STREET ADDRESS (If rural, give location) <b>8220</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Maple Lawn Rest Home</b>				d. STREET ADDRESS (If rural, give location) <b>8220</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Orville</b>			b. (Middle)			c. (Last) <b>Searcy</b>			
4. DATE OF DEATH (Month) (Day) (Year) <b>7 - 25 - 55</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>			
8. DATE OF BIRTH <b>4-4-1904</b>		9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months Days		IF UNDER 10 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			11. BIRTHPLACE (State or foreign country) <b>Mo.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13a. FATHER'S NAME <b>Bert Searcy</b>		13b. MOTHER'S MAIDEN NAME <b>Maggie Smith</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Bert Searcy</b> ADDRESS <b>Maysville Mo.</b>					
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) <b>Chronic Endocarditis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>4214</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>7</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <b>April</b> , 1947, to <b>July 25</b> , 1955, that I last saw the deceased alive on <b>July 25</b> , 1955, and that death occurred at <b>7:30 P. M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Dr. Harold Foster M.D.</b>				23b. ADDRESS <b>Maysville Mo.</b>		23c. DATE SIGNED <b>7/27/55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7-27-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Shambaugh</b>		24d. LOCATION (City, town, or county) (State) <b>weatherby Mo.</b>			
DATE REC'D BY LOCAL REG. <b>8-20-55</b>		REGISTRAR'S SIGNATURE <b>R. Davidson</b> <b>82-0</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John Brown</b> ADDRESS <b>Maysville Mo.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10. 4820  
4

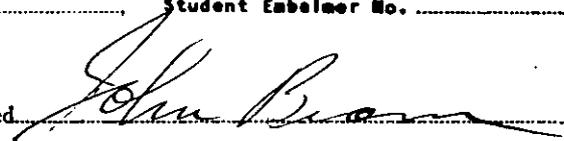
**STATEMENT BY LICENSED EMBALMER**

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.

Signed \_\_\_\_\_



Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3933

P. O. Address Ma ysville Mo<sup>u</sup>

**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.