FILED SEP 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28686

BIRTH NO. _____ REG. DIST. NO. 339 PRIMARY REG. DIST. NO. 6150 Register's No. 21

1. PLACE OF DEATH
a. COUNTY: Stoddard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kinder
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): New Lisbon Twp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Stoddard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kinder
d. STREET ADDRESS (If rural, give location): New Lisbon Twp.

3. NAME OF DECEASED (Type or Print)
a. (First): Etta
b. (Middle): Bell
c. (Last): Daniels

4. DATE OF DEATH (Month) (Day) (Year): 8 - 26 - 55

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 2 1914
9. AGE (In years last birthday): 41
If under 1 year: Months: 3 Days: 24 Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: housewife
11. BIRTHPLACE (City and State or Foreign Country): Kinder Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: James Massey
13b. MOTHER'S MAIDEN NAME: Fanny Pratt
14. NAME OF HUSBAND OR WIFE: James Daniels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: James Daniels, Kinder Mo

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis & Nephrosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

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.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
4222
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Jul, 1949, *to* 25 Aug, 1955, *that I last saw the deceased alive on* 25 Aug, 1955, *and that death occurred at* 2:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr. W. H. Merrill D.O.
23b. ADDRESS: Advance, Mo.
23c. DATE SIGNED: 27 Aug 55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-27-55
24c. NAME OF CEMETERY OR CREMATORY: Fugan Cemetery
24d. LOCATION (City, town, or county) (State): New Lisbon Twp. Mo.

DATE REC'D BY LOCAL REG.: 9/3/55
REGISTRAR'S SIGNATURE: Pearl Reed 490
25. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Advance, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Wm H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.