

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 302 Registrar's No. 81

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>HOWARD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FAYETTE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ARMSTRONG</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LEE HOSPITAL</u> Length of stay in lb <u>1 day</u>		d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALEX</u> Middle <u>W</u> Last <u>ENGLE</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>16</u> Year <u>1956</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 6, 1886</u>
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALEX ENGLES SR.</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET EMORY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Arnold Engle</u> Address <u>5007 W 127th St WORTH, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 m</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from <u>April '56</u> <u>Aug 16 '56</u> and last saw <u>him</u> alive on <u>8/16/56</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATOR <u>M. P. Reich, M.D.</u> (Degree or title)		22b. ADDRESS <u>Fayette Mo</u>	
22c. DATE SIGNED <u>8/16/56</u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>	23b. DATE <u>AUG 18 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT RIDGE</u>	23d. LOCATION (City, town, or county) (State) <u>ARMSTRONG MO.</u>
24. FUNERAL DIRECTOR <u>Audley - Friemuth</u> ADDRESS <u>2400 Grand Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>8-16-56</u>	
26. REGISTRAR'S SIGNATURE <u>Mary R. Shell</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300 1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

+36-

(Statement on Reverse Side)

SEP 4 1958

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 *J. Walker Audsley*
Licensed Embalmer No. *326*

P. O. Address *Glasgow*

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