

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27942**

BIRTH NO. **53614-56** REG. DIST. NO. **284** PRIMARY REG. DIST. NO. **3006** Registrar's No. **216**

1. PLACE OF DEATH a. COUNTY RANDOLPH			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CHARITON		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MOBERLY		c. LENGTH OF STAY (If in place) 12 HRS	c. CITY OR TOWN BRUNSWICK		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 WOODLAND HOS.			e. STREET ADDRESS (If rural, give location) 02101		

3. NAME OF DECEASED (Type or Print) a. (First) DENIECE b. (Middle) MERRY c. (Last) MERRY			4. DATE OF DEATH (Month) (Day) (Year) 8-2-1956		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 8-2-1956	9. AGE (In years last birthday) 12	IF UNDER 1 YEAR Months Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) MOBERLY MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME GARY MERRY	13b. MOTHER'S MAIDEN NAME ALMA OXLEY	14. NAME OF HUSBAND OR WIFE NONE
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME GARY MERRY	ADDRESS BRUNSWICK
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prmaturity		MEDICAL CERTIFICATION INSET BETWEEN ONSET AND DEATH 8-2-56 10:40am 8-2-56 11:15pm
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 776x
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert H Young M.D.	23b. ADDRESS Woodland Hosp	23c. DATE SIGNED 8-4-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-3-1956	24c. NAME OF CEMETERY OR CREMATORY Mc CULLOUGH	24d. LOCATION (City, town, or county) (State) TRIPLETT MO.
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DATE REC'D BY LOCAL REG. 8/3/56	REGISTRAR'S SIGNATURE Seabrook	25. FUNERAL DIRECTOR'S SIGNATURE L. M. Keessel	ADDRESS Brunswick
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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..... *L. M. Keiser*

Licensed Embalmer No. *822*.....

P. O. Address *Brunswick*.....

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.