

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30520**
Registrar's No. **63**

FILED SEP 18 1956

BIRTH NO. _____ REG. DIST. NO. **139** PRIMARY REG. DIST. NO. **4221**

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mound City 4		c. LENGTH OF STAY (in this place) 2 MOS	c. CITY OR TOWN Mound City
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kline Rest Home		d. Is Residence within limits of a city or incorporating town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) ETHEL b. (Middle) MAUDE c. (Last) KARNS		4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 13, 1885
9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Dry Goods	11. BIRTHPLACE (City and State or Foreign Country) Holt County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Austin Karns	
13b. MOTHER'S MAIDEN NAME Amelia Armack		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 488-14-7451	17. INFORMANT'S SIGNATURE OR NAME Emmett Karns, Mound City, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular Accident INTERVAL BETWEEN ONSET AND DEATH 1 wk ANTECEDENT CAUSES DUE TO (b) Accident thru train 1 wk DUE TO (c) Arteriosclerosis unknown 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"/>	
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)	332x
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 July 1, 1956 , to Sept 12, 1956 , that I last saw the deceased alive on Sept 12, 1956 and that death occurred at 2:59 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) James A. Seawright, M.D.		23b. ADDRESS Alpen, Mo	23c. DATE SIGNED 9-12-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-14-1956	24c. NAME OF CEMETERY OR CREMATORY Mount Hope	24d. LOCATION (City, town, or county) (State) Mound City, Mo.
DATE REC'D BY LOCAL REG. 9-13-56	REGISTRAR'S SIGNATURE James A. Seawright	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS James A. Seawright, Mound City, Mo.	

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

4690

SEP 28 1956

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 *James H. Crawford*

Licensed Embalmer No. *4790*

P. O. Address *Normal City*

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.