

FILED NOV 13 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36769**

BIRTH NO. _____ REG. DIST. NO. **381** PRIMARY REG. DIST. NO. **4515** Registrar's No. **86**

1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Chariton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Melan		c. CITY OR TOWN Raymond	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In place)		e. STREET ADDRESS (If rural, give location) 02101	
d. FULL NAME OF HOSPITAL OR INSTITUTION Melan Hosp			

3. NAME OF DECEASED (Type or Print) a. (First) Arthur b. (Middle) Lewis c. (Last) Hepworth	4. DATE OF DEATH (Month) (Day) (Year) 10-28-56
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 9-28-36	9. AGE (In years last birthday) 20	IF UNDER 1 YEAR: Months 1 Days 5	IF UNDER 24 HRS: Hours 5 Mins 0
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) Raymond Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Winifred Hepworth	13b. MOTHER'S MAIDEN NAME Jelda Smith	14. NAME OF HUSBAND OR WIFE -
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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. 489-426934	17. INFORMANT'S SIGNATURE OR NAME Winifred Hepworth ADDRESS: Raymond Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Neuronic shock</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	INTERVAL BETWEEN ONSET AND DEATH
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*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____
DUE TO (c) _____

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) Suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	21c. (CITY, TOWN, OR TOWNSHIP) Raymond (COUNTY) Sullivan (STATE) Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/28/56 8:40	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? auto accident
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22. I hereby certify that I attended the deceased from **10/28, 1956** to **10/28, 1956**, that I last saw the deceased alive on **10/28, 1956**, and that death occurred at **3:50 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. J. Harris (Degree or title) S.D.	23b. ADDRESS Harris, Mo	23c. DATE SIGNED 10/29/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-1-56	24c. NAME OF CEMETERY OR CREMATORY Johnson Cem.	24d. LOCATION (City, town, or county) (State) Raymond Mo
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DATE REC'D BY LOCAL REG. 11-9-56	REGISTRAR'S SIGNATURE Mrs. M. W. Beckett	25. FUNERAL DIRECTOR'S SIGNATURE Henry S. Edwards ADDRESS Raymond Mo
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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.....
Signature of Student Embalmer

Signed *J. S. Edwards*

Licensed Embalmer No. *196*

P. O. Address *Bevier*

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.