

FILED DEC 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38734**

BIRTH NO. _____		REG. DIST. NO. 200		PRIMARY REG. DIST. NO. 5732		Registrar's No. 238	
1. PLACE OF DEATH a. COUNTY Macon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY Macon			
b. CITY (If outside corporate limits, write RURAL and give township) South Gifford c. LENGTH OF STAY (in this place) 4c				c. CITY OR TOWN South Gifford		d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				e. STREET ADDRESS (If rural, give location) 06100			
3. NAME OF DECEASED (Type or Print)		a. (First) Harvey		b. (Middle) S.		c. (Last) Waddill	
4. DATE OF DEATH December 5 1956		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH February 18 1869		9. AGE (in years last birthday) 87		10. MONTHS 9		11. DAYS 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Adair County Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME George M. Waddill		13b. MOTHER'S MAIDEN NAME Martha Sparks		14. NAME OF HUSBAND OR WIFE Nellie G. Waddill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Nellie G. Waddill ADDRESS South Gifford 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia				ANTECEDENT CAUSES. DUE TO (b) Widespread metastasis			
DUE TO (c) Cancer of prostate				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 177X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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 5/18/55 , 19__, to 12/5/56 , 19__, that I last saw the deceased alive on 12/3/56 , 19__, and that death occurred at 2-40 P m. , from the causes and on the date stated above.							
23a. SIGNATURE [Signature] (Degree or title) D.O.				23b. ADDRESS South Gifford Mo		23c. DATE SIGNED 12-7-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec 9 1956		24c. NAME OF CEMETERY OR CREMATORY Mt Carmel		24d. LOCATION (City, town, or county) (State) Adair County Mo	
DATE REC'D BY LOCAL REG. 12/8/56		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS South Gifford Mo	

(Licensed Embalmers' Statement on Reverse Side)

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

Date Filed 12.12.52

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 *W H McCallum*

Licensed Embalmer No. 2052

P. O. Address South Gifford

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.