300
48

FILED JAN 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 412

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 136

1. PLACE OF DEATH
a. COUNTY: Butler
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Poplar Bluff
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Poplar Bluff Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Carter
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellsinor, Mo. 0180
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Rainey
b. (Middle): Baker
c. (Last): Julian

4. DATE OF DEATH (Month) (Day) (Year): Jan. 22 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 25/1870
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months 4 Days 27 — IF UNDER 24 HRS.: Hours Min.

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): Wayne Co. Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Dr Wiley Julian
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: Mary Link Julian

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.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mr George Julian Ellishore 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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) double Pneumonia
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: 490x
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* 1-22-, 1957 *to* 1-22-, 1957 *that I last saw the deceased alive on* 1-22-, 1956, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. H. James M.D.
23b. ADDRESS: Piedmont Mo.
23c. DATE SIGNED: 1-24-57

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/24/57
24c. NAME OF CEMETERY OR CREMATORY: Owl Roost
24d. LOCATION (City, town, or county) (State): Carter Co Mo.

DATE REC'D BY LOCAL REG.: 1/25/57
REGISTRAR'S SIGNATURE: R H Mueller
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Soder Piedmont Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
JAN 28 1957
BUTLER CO. HEALTH CENTER
FILE No. _____

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 _____
Coder Funeral Home Student Embalmer No. _____
working under my personal supervision.

Student _____
Student Embalmer

Signed William Coder
Licensed Embalmer No. 3723
P. O. Address Piedmont, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.