

pt. Health,
& Welfare
S. Public
h Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39205

STATE FILE NUMBER

FILED DEC 10 1957 Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 49

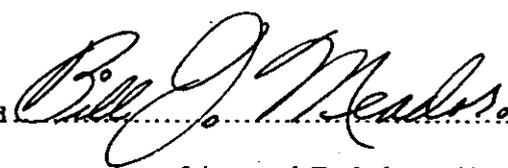
1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Boone				
b. CITY (If outside corporate limits, give TOWNSHIP only) Centralia			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Centralia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) Way Nursing Home			Length of stay in lb 5 mo.	d. STREET ADDRESS (If outside, give location) 329 South Allen		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Levi Edwin Detrick				First	Middle	Last	4. DATE OF DEATH Month Dec Day 2 Year 1957	
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 26 1876		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 10 Days 6 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 country) Marshall Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Detrick				14. MOTHER'S MAIDEN NAME Amadilla Huddleston				
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. 478-12-1738		17. INFORMANT Mrs. Bernice Hargis, Centralia Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Stokes-Adams Syndrome DUE TO (c) Anterior chestic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH Just Many months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. 			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 11-21-57 to 12-2-57 and last saw her/him alive on 12-1-57 Death occurred at 12:05 P m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE J. P. Baker, D.O. (Degree or title)				22b. ADDRESS Centralia, Mo.			22c. DATE SIGNED 12-3-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)
Removal		Dec 5, 1957		Avon Cemetery		Des Moines, Iowa		
24. FUNERAL DIRECTOR Willie M. Meador Centralia, Missouri				25. DATE RECD. BY LOCAL REG. Dec 3, 1957		26. REGISTRAR'S SIGNATURE Maud McBride		

(Licensed Embalmer's Statement on Reverse Side)

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 

Licensed Embalmer No. 4877

P. O. Address Centralia, W. Va.

**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.**