

pt. Health,
, & Welfare
S. Public
with Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 16 1958

41803
STATE FILE NUMBER

Registration District No. 369 Primary Registration District No. 6257 Registrar's No. 1

pt. S. 300
ev. 1-
RECEIVED
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
Securing the medical certificate in this specific manner is required by 193.140 R.S.M.S. 1947.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Wayne</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Logan Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Patterson (Rural)</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Range Creek</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED - (Type or print) First <u>Elias</u> Middle <u>Butler</u> Last <u>White</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE (In years last birthday) <u>87</u> IF UNDER 1 YEAR Months <u>X</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11a. FATHER'S NAME <u>James H. White</u>		11b. MOTHER'S MAIDEN NAME <u>Sarah Wakefield</u>	11c. NAME OF HUSBAND OR WIFE <u>Loan Myers White</u>
13a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		13b. SOCIAL SECURITY NO.	13c. INFORMANT <u>Mr Orlie White</u> Address <u>Patterson Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>senile dementia</u> DUE TO (b) <u>arthritis in the lumbar region</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
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"/> <u>2</u>
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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>			
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 <u>1955</u> to <u>12/23/1957</u> and last saw her/him alive on <u>12-22-1957</u> Death occurred at <u>6 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. J. Jones, M.D.</u>		22b. ADDRESS <u>Piedmont, Missouri</u>	22c. DATE SIGNED <u>12-26-'57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beulah</u>	23d. LOCATION (City, town, or county) (State) <u>Brunot Mo.</u>
24. FUNERAL DIRECTOR <u>William Bohm</u> ADDRESS <u>Piedmont</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 10, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Hazel Ward</u>

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WAYNE CO. HEALTH CENTER

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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
Signature of Student Embalmer

Signed William Coder

Licensed Embalmer No. 3723

P. O. Address Piedmont, W

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.