

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-825296
STATE FILE NUMBER

NEW JUL 28 1958 Registration District No. 144 Primary Registration District No. 4237 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY Iron		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Iron	
b. CITY (If outside corporate limits, give TOWNSHIP only) Ironton		c. CITY OR TOWN Ironton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 203 W Wayne		d. STREET ADDRESS (If outside, give location) 203 W Wayne	
Length of stay in lb 20 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JAMES Middle DUBACHER Last DUBACHER			4. DATE OF DEATH Month July Day 6 Year 1958			
---	--	--	---	--	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2 1878	9. AGE (In years last birthday) 80	FUNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
--------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tavern operator	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Graniteville Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	---	--

13a. FATHER'S NAME Joseph Dabacher	13b. MOTHER'S MAIDEN NAME Elixabeth Jaycox	14. NAME OF HUSBAND OR WIFE ##
--	--	--

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 Address Clayborne Orrick, Middlebrook 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) acute myocarditis		INTERVAL BETWEEN ONSET AND DEATH 3 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) far advanced arterio-sclerosis		?
DUE TO (c) 4221		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) diabetic mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 8.30 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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 3-17-58 , to 7-6-58 and last saw ^{her} him alive on 7-6-58 Death occurred at 8.30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE R. E. Harland M.D. (Degree or title)	22b. ADDRESS Ironton Mo	22c. DATE SIGNED 7/9/58.
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-9-58	23c. NAME OF CEMETERY OR CREMATORY Arcadia Valley Memorial Park, Ironton Mo.	23d. LOCATION (City, town, or county) (State)
---	----------------------------	--	---

24. FUNERAL DIRECTOR White Funeral Home, Ironton Mo.	25. DATE RECD. BY LOCAL REG. 7-10-58	26. REGISTRAR'S SIGNATURE Ma Avis Jones
--	--	---

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S. 300
1-57
0470
1

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 *Amel J. White*

Licensed Embalmer No. *7012*

P. O. Address *Proctor, Me.*

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.