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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005335
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 139 Primary Registration District No. Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY: HOLT
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Mound City — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in Ib: 43 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Holt
c. CITY OR TOWN: Mound City — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: FRANK Middle: ALVIN Last: DOAN
4. DATE OF DEATH: Month Feb. Day 19 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN 25 1890
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and state or country): CARROLLTON Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: DAVID DOAN
13b. MOTHER'S MAIDEN NAME: NANCY HOLLAND
14. NAME OF HUSBAND OR WIFE: GOLDIE DOAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 496-10-9925
17. INFORMANT: MRS. GOLDIE DOAN Address: MOUND CITY MO.

MEDICAL CERTIFICATION

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 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

21. I attended the deceased from February 19, 1959 to February 19, 1959 and last saw her/him alive on Feb. 19, 1959
Death occurred at 8:15 a.m. p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Nat W Kinney (Degree or title): MD
22b. ADDRESS: Mound City Mo.
22c. DATE SIGNED: Feb 21, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 2/22/59
23c. NAME OF CEMETERY OR CREMATORY: Mount Hope
23d. LOCATION (City, town, or county): Mound City (State): Mo.

24. FUNERAL DIRECTOR: James H Crawford ADDRESS: Mound City Mo.
25. DATE RECD. BY LOCAL REG.: 2/21/1959
26. REGISTRAR'S SIGNATURE: James H Crawford
(Licensed Embalmer's Statement on Reverse Side)

APR 7 1959 MAR 5 1959 MAR 23 1959

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 James H Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City, M

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.