

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009198

STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 138 Primary Registration District No. Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>	
b. CITY OR TOWN <u>Wheatland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Wheatland, Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>700 MAIN ST</u>		d. STREET ADDRESS (If outside, give location) <u>Main St</u>	
Length of stay in lb <u>7 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Oral</u> Middle <u>Doan</u> Last <u>Doan</u>			4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18-1880</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Hickory Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Wm Doan</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Williamson</u>	14. NAME OF HUSBAND OR WIFE <u>Dora Doan</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>John W. Dickham Kansas City Mo</u>	Address <u></u>
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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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Smoking & arteriosclerosis</u>	DUE TO (c) <u>4201</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"/>

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.)
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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
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21. I attended the deceased from <u>1950</u> to <u>March 24, 1959</u> and last saw her alive on <u>March 24, 1959</u> Death occurred at <u>6:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE (Degree or title) <u>J. E. Briggs, DO</u>	22b. ADDRESS <u>Wheatland, Mo.</u>	22c. DATE SIGNED <u>4-3-59</u>
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23a. FUNERAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar 28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dooley Bend Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wheatland Mo.</u>
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24. FUNERAL DIRECTOR <u>Robert McWhorter - Wheatland, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-4-1959</u>	26. REGISTRAR'S SIGNATURE <u>May Johnson</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Charles Herbert Johnson*

Licensed Embalmer No. *4267*.....

P. O. Address *Leicester, Mass.*

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.