

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022196

STATE FILE NUMBER

FILED JUN 19 1959

Registration District No. 212 Primary Registration District No. 5779 Registrar's No. 11

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>MILLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ANDRAIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EIDON</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>FARBER</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>LAKE OF THE OZARKS.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>LEE</u> Last <u>DEORNELLAS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</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>AUG. 16, 1930</u>		9. AGE (In years last birthday) <u>29</u> 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) <u>MOULDER - BRICK PLANT</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>STROTHER, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>STEVE DEORNELLAS</u>	13b. MOTHER'S MAIDEN NAME <u>MATHERYN LYDIA KIDD</u>	14. NAME OF HUSBAND OR WIFE <u>BETTY PUTNAM DEORNELLAS</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>	16. SOCIAL SECURITY NO. <u>492-34-6933</u>	17. INFORMANT Address <u>MRS. H.L. DEORNELLAS FARBER, 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>SUFFOCATION by DROWNING</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<u>850X</u>
	DUE TO (c)	
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 checked="" 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.) <u>FELL FROM MOVING MOTOR BOAT</u>
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ <u>11:15 p.m. MAY 31, 1959</u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>LAKE OF THE OZARKS</u>	20f. CITY, TOWN, OR LOCATION <u>EIDON</u>	COUNTY <u>MILLER</u>	STATE <u>MO.</u>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Herman V. Abbott, Sheriff</u>	22b. ADDRESS <u>Jacksonville, MO.</u>	22c. DATE SIGNED <u>6-6-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JUNE 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FARBER</u>	23d. LOCATION (City, town, or county) (State) <u>FARBER, MO.</u>
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24. FUNERAL DIRECTOR <u>Louis D. Phillips</u>	ADDRESS <u>Ladue</u>	25. DATE RECD. BY LOCAL REG. <u>June 6, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Alverta Wall</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

JUL 6 7 1958

JUL 6 7 1958

JUL 6 7 1958

JUL 6 7 1958

Miller County
Health Department

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 *Paul W. Phillips*

Licensed Embalmer No. *3663*

P. O. Address *Edna*

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.