

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004281

FILED VS JAN 16 1967

Registration District No. 925 Primary Registration District No. 4478 Registrar's No. 13

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Schuyler County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCHUYLER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LANCASTER</u>		Length of stay in 1b <u>1.5 YR.</u>	c. CITY OR TOWN <u>LANCASTER</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>AT, NONE</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>ZILBA</u> Middle <u>SEYMOUR</u> Last <u>DARNIELLE</u>	4. DATE OF DEATH Month <u>JAN.</u> Day <u>7,</u> Year <u>1961</u>
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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>APRIL 1, 1901</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR 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>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>DAVIS COUNTY, IOWA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>GEORGE W. DARNIELLE</u>	13b. MOTHER'S MAIDEN NAME <u>VIRGINIA KINSLER</u>	14. NAME OF HUSBAND OR WIFE <u>HAZEL DARNIELLE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>HAZEL DARNIELLE; LANCASTER, MO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary failure</u> DUE TO (b) <u>Hypertensive cardiovascular disease</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>2 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) <u></u>
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></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></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from <u>Oct. 29, 1957</u> to <u>Jan. 7, 1961</u> and last saw him alive on <u>1-7-61</u> Death occurred at <u>12:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>M.R. Stokard</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Lancaster Mo.</u>	22c. DATE SIGNED <u>1-9-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 9 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMPHIS MO</u>	23d. LOCATION (City, town, or county) <u>MEMPHIS MO</u>	(State) <u></u>
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24. FUNERAL DIRECTOR <u>NORMANS LANCASTER MO</u>	25. DATE RECD. BY LOCAL REG. <u>1-9-1961</u>	26. REGISTRAR'S SIGNATURE <u>Geo. P. Drake</u>
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DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ BY AFFIDAVIT OF

FEB 1 1961

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 David E. Foster

Licensed Embalmer No. 4742

P. O. Address Suburban

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.