

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12694**

BIRTH NO. _____ REG. DIST. NO. **223** PRIMARY REG. DIST. NO. **4334** Registrar's No. **26**

1. PLACE OF DEATH a. COUNTY Moniteau Co		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Moniteau	
b. CITY (If outside corporate limits, write RURAL and give town) Latham Mo		c. CITY (If outside corporate limits, write RURAL and give township) Latham, Mo	
c. LENGTH OF STAY (in this place) 7 1/2 Yrs		d. STREET ADDRESS (If rural, give location) Latham, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home. Latham, Mo			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Forest c. (Last) Vernon			4. DATE OF DEATH (Month) (Day) (Year) Apr 25 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 18 1880	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 7 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Vernon	13b. MOTHER'S MAIDEN NAME Annie Hunziker	14. NAME OF HUSBAND OR WIFE Annie Vernon
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Carlos Vernon, S. City, Mo.	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Less than 1 yr 4 + years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis with DUE TO (c) Myocardial Degeneration		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Latham Moniteau Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from **11-20**, 1954, to **2-28**, 1955, that I last saw the deceased alive on **2-28**, 1955, and that death occurred at **6:30 AM.**, from the causes and on the date stated above.

23a. SIGNATURE RS Fisher (Degree or title) MD	23b. ADDRESS California, Mo.	23c. DATE SIGNED 4-26-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/27/55	24c. NAME OF CEMETERY OR CREMATORY Woodman Cemetery	24d. LOCATION (City, town, or county) (State) High Point, Mo
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DATE REC'D BY LOCAL REG. 4-27-55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Earl Bowlin ADDRESS California
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed.....

Jack A. Bocolin

Signed.....
Student Embalmer

Licensed Embalmer No. *4933*

P. O. Address *California, Mo.*

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 this body is not embalmed, fact should be so stated above.