

FILED AUG 13 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26545

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 127

1. PLACE OF DEATH:

(a) County Washburn
(b) City or town Washburn
(c) Name of hospital or institution State Hospital #3
(d) Length of stay: In hospital or institution 1 1/2 mo 15 days
In this community 1 year 2 months 15 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Springfield
(d) Street No. 0
(e) If foreign born, how long in U. S. A. no years.

3. (a) PRINT FULL NAME LYDIA AVEN

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12-4-1876
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 17 If less than one day hr. 5 min.

9. Birthplace Fontanelle Adm Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wif. Mc Broom

13. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Reynolds

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital record
(b) Address Nebraska, no.

17. (a) Removal (b) Date thereof 7-31-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ozark, Mo.
18. (a) Signature of funeral director Steph F. Service
(b) Address Nebraska, no.

19. (a) 7-31-47 (b) Kathryn Hansen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1947 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from July 15 1947 to July 31 1947
that I last saw her alive on July 30 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pericardial Anemia

Due to _____

Due to _____

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: ✓
Of operations: ✓
Of autopsy: ✓

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) _____
While at work? _____ (c) Means of injury 0

23. Signature R. P. Hall (M. D. or other) MD
Address Nebraska, no. Date signed 7-31-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
CLERK HEALTH OFFICER NO. 7,
7-47-93-8
District File Number 8-19-47
Date Filed

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *J. H. Marmaduke*

Licensed Embalmer No. 2070

P. O. Address Prwada, 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, above space should be left blank.