

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8287

FILED APR 8 1948 3

State File No. _____

Registration District No. _____

Primary Registration District No. 4154

Registrar's No. 24

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Greenfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
203 South Main Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XXXX (Specify whether
In this community 78 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dade
(c) City or town Greenfield
(If outside city or town limits, write "RURAL")
(d) Street No. 203 South Main Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3. (a) PRINT FULL NAME LUCY B. KILLINGSWORTH
(b) If veteran, No name war
(c) Social Security No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 7 year 1948 hour 5 minute A. M.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, divorced, or married Widowed
(b) Name of husband or wife XXXXXX
(c) Age of husband or wife if alive XXX years
7. Birth date of deceased August 25 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/29/48 to 3/7/48 that I last saw her alive on 3/5/48 and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 6 Days 9 If less than one day hr. min.

Immediate cause of death Uremia
Due to Chronic nephrosis

9. Birthplace Dade County Missouri
(City, town, or county) (State or foreign country)

Other conditions Hypertensive C-V disease
(Include pregnancy within 6 months of death)
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Home
11. Industry or business Home

MOTHER FATHER
12. Name John Owings
13. Birthplace No Record
(City, town, or county) (State or foreign country)
14. Maiden name Charity Ann Owings
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Ted R. Killingsworth
(b) Address Greenfield, Mo.

Major findings:
Of operations _____
Of autopsy _____

17. (a) Burial (b) Date thereof 3-9-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hickory Grove Cemetery

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?

18. (a) Signature of funeral director Sam E. Senseney Jr.
(b) Address Greenfield, Mo.

While at work? (Specify type of place)
(c) Means of injury

19. (a) 3-9-48 (b) Geo R. Killingsworth
(Date received local registrar) (Registrar's signature)

23. Signature A. R. Camp M.D. (M. D. or other)
Address Greenfield Date signed 3/8/48

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

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RECEIVED

District Health Officer No. 6

District File Number 348-373

Date Filed 12 11 1948

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 Sam E. Genserey Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield, 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.