

V. S. No. 300
REV. 10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40920

State File No. _____

FILED JAN 10 1949

BIRTH NO. _____ REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 3048 Registrar's No. 308

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville	
c. LENGTH OF STAY (in this place) 12 yrs		d. STREET ADDRESS (If rural, give location) 123 So. Mulberry	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) SARAH	b. (Middle) EVA	c. (Last) POPE	4. DATE OF DEATH (Month) (Day) (Year)
				12 22 1948

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 28, 1872	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Rockville, Indiana / 90	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Boyd Pence	13b. MOTHER'S MAIDEN NAME Malinda Southard	14. NAME OF HUSBAND OR WIFE Clarence M. Pope
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Floyd A. Pope, Maryville, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Intertumoral Obstruction DUE TO (c) Serulity		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 12/13/48	19b. MAJOR FINDINGS OF OPERATION Intertumoral Obstruction	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12/4**, 19**48**, to **Dec. 22, 1948**, that I last saw the deceased alive on **12/22**, 19**48**, and that death occurred at **9:30 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) B. S. Byland M.D.	23b. ADDRESS Maryville, Missouri	23c. DATE SIGNED 12/23/48
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 12/24/48	24c. NAME OF CEMETERY OR CREMATORY St. Patrick's	24d. LOCATION (City, town, or county) (State) Maryville, Mo.
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DATE REC'D BY LOCAL REG. 12-31-48	REGISTRAR'S SIGNATURE Beas Holt	25. FUNERAL DIRECTOR'S SIGNATURE John W. Price	ADDRESS Maryville, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

74
1
2

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.....
Student Embalmer

Signed

John W. Price

Licensed Embalmer No. *4281*

P. O. Address *Maryville 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Jan*Registration District No. *251*Primary Registration District No. *3048*Registrar's No. *308*

1. PLACE OF DEATH:

(a) County *Nodaway*
(b) City or town *Marionville*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community
years, months or days)3. (a) PRINT
FULL NAME *Irak E. Papp*3. (b) If veteran,
name war3. (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
alive7. Birth date of deceased *Jan 28*
(Month) (Day) (Year)8. AGE: Years Months Days *76* If less than one day
hr. min.9. Birthplace *Ind*
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
{ 12. Name
{ 13. Birthplace (City, town, or county) (State or foreign country)
{ 14. Maiden name
{ 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan*
year *1948* hour *2* minute *2* M.21. I hereby certify that I attended the deceased from
to
that I last saw him alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

Duration

Due to *large gallstones*
in the liver

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?

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

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

S-40920

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