

FILED JAN 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41014
21715

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>378</u>		
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>41 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2103 South Limit Ave</u>				d. STREET ADDRESS (If rural, give location) <u>2103 South Limit Ave.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMMA</u>		b. (Middle) <u>CLYDE</u>		c. (Last) <u>ERVIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 18, 1948</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 26, 1874</u>		
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months <u>2</u> Days _____		IF UNDER 100 Hrs. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (State or foreign country) <u>Versailles, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Michael H. Stover</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Ellen Hunter</u>			14. NAME OF HUSBAND OR WIFE <u>William Frank Ervin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Colman Ervin, son, 2103 S. Limit</u>				
				ADDRESS <u>Sedalia, Mo.</u>				
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. <u>112</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Status Asthmaticus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>don't know</u> DUE TO (c) <u>-</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>no</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 YR</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)				
				<u>none</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>1934</u> , 19 <u>34</u> , to <u>12/17</u> , 19 <u>48</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>48</u> , and that death occurred at <u>6 A.</u> m., from the causes and on the date stated above. <u>D</u>								
23a. SIGNATURE <u>W.D. Oyer M.D.</u> (Degree or title)				23b. ADDRESS <u>Sedalia Mo</u>		23c. DATE SIGNED <u>12/20/48</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/21/48</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>12/21/48</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>25</u>		ADDRESS <u>Sedalia, Mo.</u>		

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-11-49

*Dr. J. W. ...
Sedalia
Mo.*

JAN 9 1949
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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 _____

RICHARD D. CONN

Student Embalmer No. 261

working under my personal supervision.

Signed Richard D. Conn
Student Embalmer

Signed Dr. J. W. Ewing

Licensed Embalmer No. 3847

P. O. Address Sedalia 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.