

FILED JUN 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42971**

BIRTH NO. _____ REG. DIST. NO. **151** **DELAYED** REG. DIST. NO. **2001** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Joplin		c. CITY (If outside corporate limits, write RURAL and give township) Sarsawie	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hosp			

3. NAME OF DECEASED (Type or Print) a. (First) VETA b. (Middle) -LEE c. (Last) FOLLIS			4. DATE OF DEATH (Month) (Day) (Year) July 24-1948
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5. SEX F	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7-21-1887	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Carl Junction, Mo	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME Art Madden	13b. MOTHER'S MAIDEN NAME Mary Lewis	14. NAME OF HUSBAND OR WIFE Albert N. Sarsawie Mo
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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) ✓	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Albert N. Follis ADDRESS Sarsawie Mo
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Vagina		INTERVAL BETWEEN ONSET AND DEATH 3 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause* (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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) _____
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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? _____
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22. I hereby certify that I attended the deceased from _____, 1948, to _____, 1948, that I last saw the deceased alive on **6-20, 1948**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE M. F. Hill MD (Degree or title)	23b. ADDRESS Joplin Mo	23c. DATE SIGNED 6-24-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-25-48	24c. NAME OF CEMETERY OR CREMATORY Sarsawie Mo	24d. LOCATION (City, town, or county) (State) Sarsawie Mo
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DATE REC'D BY LOCAL REG. 6-24-49	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Jackson & Sons ADDRESS Surget Mo
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(Licensed Embalmer's Signature on Reverse Side)

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

49
2
5

187

AUG 1 1948

REC'D
JUN 9 1948

JUN 28 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 me

Student Embalmer No. _____

working under my personal supervision.

Signed Wm A Jackson

Licensed Embalmer No. 3954

Signed _____
Student Embalmer

P. O. Address Larcorke 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.