

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 535

BIRTH NO. _____		REG. DIST. NO. <u>56</u>		PRIMARY REG. DIST. NO. <u>4080</u>		Registrar's No. <u>5</u>	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Norborne</u>		c. LENGTH OF STAY (in this place) <u>Lifetime</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Norborne</u>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>506 East Second Street</u>				d. STREET ADDRESS (If rural, give location) <u>506 East Second Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Browning</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 30, 1949</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>Nov. 11, 1866</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Howland Little</u>			13b. MOTHER'S MAIDEN NAME <u>Hester Goldman Crestworth</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT'S SIGNATURE OR NAME <u>Roy Browning</u> ADDRESS <u>Norborne, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Epidermoid carcinoma of left labium maj- orum</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Coronary sclerosis</u> <u>Arteriosclerosis, cerebral & diffuse</u> <u>176X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u> <u>unknown</u>
19a. DATE OF OPERATION <u>11-17-47</u>		19b. MAJOR FINDINGS OF OPERATION <u>Vulvectomy. Carcinoma of vulva.</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) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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>10-17-46</u> , 19 <u> </u> , to <u>1-30-49</u> , 19 <u> </u> , that I last saw the deceased alive on <u>1-30-49</u> , 19 <u> </u> , and that death occurred at <u>4:00 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Ralph E. Haskell M.D.</u> (Degree or title)				23b. ADDRESS <u>212 South Pine Street</u> <u>Norborne, Missouri</u>		23c. DATE SIGNED <u>1-31-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 1-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairhaven Norborne</u>		24d. LOCATION (City, town, or county) (State) <u>Norborne Mo</u>	
DATE REC'D BY LOCAL REG. <u>Feb 1st 1949</u>		REGISTRAR'S SIGNATURE <u>Eileen Pennington</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Deitch</u> ADDRESS <u>Norborne Mo</u>			

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

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RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-10-49

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.

Student
Student Embalmer

Signed John G. Deitch
Licensed Embalmer No. 3654

P. O. Address Northome 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.