

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 20 1949

State File No. 1732

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

BIRTH NO. <u>174</u>		REG. DIST. NO. <u>5-244</u>		PRIMARY REG. DIST. NO. <u>5644</u>		Registrar's No. <u>15</u>	
1. PLACE OF DEATH a. COUNTY <u>LAFAYETTE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFAYETTE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>LEXINGTON</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>LEXINGTON</u>		d. STREET ADDRESS (If rural, give location) <u>RURAL</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RURAL</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>DELLA</u>			b. (Middle) <u>MAE</u>		c. (Last) <u>OHES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-9-1949</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>10-26-1879</u>	9. AGE (In years last birthday) <u>69</u>	# UNDER 1 YEAR Months <u>2</u> Days <u>13</u>	# UNDER 1 HR. Hours <u></u> Min. <u></u>
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		11. BIRTHPLACE (State or foreign country) <u>HICKORY, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>A-S-A</u>	
13a. FATHER'S NAME <u>A. J. GRAY</u>			13b. MOTHER'S MAIDEN NAME <u>ISABEL KINNEB</u>		14. NAME OF HUSBAND OR WIFE <u>STEPHEN OHES</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>STEPHEN OHES</u>				ADDRESS <u>LEX. 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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial Degeneration</u> <u>Chronic Myocarditis</u> <u>Coronary Atherosclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage & Hemiplegia</u> DUE TO (c) <u>Hypertension & Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>8 weeks</u> <u>indefinite</u> <u>15 yrs</u>
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. CITY, TOWN, OR TOWNSHIP <u>Lexington</u>		COUNTY (STATE) <u>Lafayette Missouri</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>48</u> , to <u>1-9</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1-9</u> , 19 <u>49</u> , and that death occurred at <u>10:30 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. J. C. Bellman</u>				23b. ADDRESS <u>Dr. O. Lexington, Mo.</u>		23c. DATE SIGNED <u>1-10-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>1-12-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MACH DELAH CEM</u>		24d. LOCATION (City, town, or county) (State) <u>LEXINGTON, MO</u>			
DATE REC'D BY LOCAL REG. <u>Jan 26-49</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Schuchert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>FOREST F TEMPEL</u>		ADDRESS <u>LEX. MO.</u>	

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. 29839

P. O. Address Lexington, Mass.

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.