No. 300
10-48

FILED JAN 16 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2223

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 4427 Registrar's No. 15

1. PLACE OF DEATH
a. COUNTY: Pulaski
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Waynesville
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Waynesville General

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Texas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Big Piney
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): Elvira
c. (Last): Jefferies

4. DATE OF DEATH (Month) 1 (Day) 11 (Year) 49

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10-23-1870
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months 2, Days 19 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Linn Creek, Missouri
12. CITIZEN OF WHAT COUNTRY?: U S

13a. FATHER'S NAME: John Webb
13b. MOTHER'S MAIDEN NAME: Nancy
14. NAME OF HUSBAND OR WIFE:

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: Etha Hood — ADDRESS: 2402 A. Cass Ave St. Louis

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia - Bronchial

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. Chronic Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6, 1949, *to* 1-11, 1949, *that I last saw the deceased alive on* 1-11, 1949, *and that death occurred at* 3:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm R Lythe M.D.
23b. ADDRESS: Waynesville, Mo
23c. DATE SIGNED: 1-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 1-11-49
24c. NAME OF CEMETERY OR CREMATORY: Big Piney Cemetery
24d. LOCATION (City, town, or county) (State): Big Piney, Missouri

DATE REC'D BY LOCAL REG.: 1-15-49
REGISTRAR'S SIGNATURE: Thelma C. Buckthorp 389
25. FUNERAL DIRECTOR'S SIGNATURE: Gaylord V. Elliott — ADDRESS: Houston, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student _____
Student Embalmer

Signed Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.