

FILED MAR 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4588
State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 192

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (in this place) <u>4 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>805 Page St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>805 Page St.</u>		e. FULL NAME OF HOSPITAL OR INSTITUTION	
3. NAME OF DECEASED (Type or Print) <u>Mary Ponder</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 26 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>March 9 1869</u>
9. AGE (In years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Marion Co. Mo.</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John F. Dodds</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Powers</u>	14. NAME OF HUSBAND OR WIFE <u>O. F. Ponder</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. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lloyd Ponder Springfield Mo.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 Months</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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.		<u>154X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)	
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 <u>✓</u>		22. I hereby certify that I attended the deceased from <u>March, 1948</u> , to <u>Feb 26</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>49</u> , and that death occurred at <u>4:15 A. m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>Max Fitch</u> (Degree or title)		23b. ADDRESS <u>Springfield Mo.</u>	
23c. DATE SIGNED <u>3-1-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal & Burial</u>	
24b. DATE <u>Feb. 27, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bear Thicket Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Laclede Co. Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.E. Holman Lebanon Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3/4/49</u>		REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 24 1949

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 Orsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.