No. 300
No. 48

FILED MAR 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7233

BIRTH NO. _____ REG. DIST. NO. 373 PRIMARY REG. DIST. NO. 6269 Registrar's No. 10

112
0
0

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

1. PLACE OF DEATH
a. COUNTY: Webster
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Ozark Twp
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): County Farm 5

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Webster 112
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ✓ 0 0
d. STREET ADDRESS (If rural, give location): 10

3. NAME OF DECEASED (Type or Print): a. (First) Addie b. (Middle) c. (Last) Lockhart

4. DATE OF DEATH (Month) Feb (Day) 17 (Year) 1949

5. SEX: F 1
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 13 1868
9. AGE (In years last birthday): 80 | IF UNDER 1 YEAR Months: 7 Days: 4 | 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): Marion Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Ray Lockhart

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: ADDRESS:

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) Double Lobar Pneumia

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: No
19b. MAJOR FINDINGS OF OPERATION: No
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* Feb 1, 1949, *to* Feb 19, 1949, *that I last saw the deceased alive on* Feb 17, 1949, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W F Schuchtmann MD
23b. ADDRESS: Niongia Mo
23c. DATE SIGNED: Feb 19/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2-19-49
24c. NAME OF CEMETERY OR CREMATORY: Seymour Cemetery
24d. LOCATION (City, town, or county): Seymour (State) Mo

DATE REC'D BY LOCAL REG.: 3/5/49
REGISTRAR'S SIGNATURE: J Hanner
25. FUNERAL DIRECTOR'S SIGNATURE: Kelley, Ferrell, Bergman
ADDRESS: Seymour, Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 349-292
Date Filed 3-8-49

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 ..... Student Embalmer No. ..... working under my personal supervision.

Signed H. K. Kelley

Signed ..... Student Embalmer

Licensed Embalmer No. 3334

P. O. Address Fordland Mo.

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

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