

FILED APR 5 1949

STANDARD CERTIFICATE OF DEATH

State File No. 9681

BIRTH NO. 49-017218 REG. DIST. NO. 814 PRIMARY REG. DIST. NO. 4459 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) Osceola		c. CITY (If outside corporate limits, write RURAL and give township) Osceola	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1			

3. NAME OF DECEASED (Type or Print) Elizabeth		b. (Middle) --		c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) Mar 30 49	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 3/29	
9. AGE (In years last birthday) 1		10. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Osceola Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Bob Terent		13b. MOTHER'S MAIDEN NAME Mabel Jones		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Otis Jones ADDRESS Osceola Mo.	

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) Congenital debility		INTERVAL BETWEEN ONSET AND 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.		75H²	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		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)		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 3/29, 1949, to 3/30, 1949, that I last saw the deceased alive on 3/30, 1949, and that death occurred at 3 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. Mark Todd, M.D.		23b. ADDRESS Osceola, Mo.		23c. DATE SIGNED 3/31/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/31/49		24c. NAME OF CEMETERY OR CREMATORY Osceola Cemetery	
				24d. LOCATION (City, town, or county) (State) Osceola Missouri	

DATE REC'D BY LOCAL REG. April 1-49		REGISTRAR'S SIGNATURE Ruth Seewers		25. FUNERAL DIRECTOR'S SIGNATURE F. B. Goodrich ADDRESS Osceola Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

93
92

RECEIVED

District Health Officer No. 7;

District File Number 3-49-514

Date Filed 4-4-49

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.

Student
Student Embalmer

Signed J. B. [Signature]

Licensed Embalmer No. 3038

P. O. Address Osceola, 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.