

FILED APR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12091

State File No.

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

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 376	
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Webster			
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. LENGTH OF STAY (in this place) 1 day		c. CITY (If outside corporate limits, write RURAL and give township) Niangua		112	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital				d. STREET ADDRESS none			
3. NAME OF DECEASED (Type or Print) a. (First) Dorothy			b. (Middle) Smith		c. (Last) Sawyer		4. DATE OF DEATH (Month) (Day) (Year) April 25, 1949
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 18, 1914	9. AGE (In years last birthday) 35	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	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 Housewife		11. BIRTHPLACE (State or foreign country) Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Otis Smith			13b. MOTHER'S MAIDEN NAME Kay Letterman		14. NAME OF HUSBAND OR WIFE Hugh R. Sawyer		
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Donald Sawyer Niangua, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia ANTECEDENT CAUSES DUE TO (b) Obstruction of the bowel DUE TO (c) Volvolesis 7/3 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5/23					INTERVAL BETWEEN ONSET AND DEATH
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) (m.)		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 April 24, 1949 , to April 25, 1949 , that I last saw the deceased alive on April 19, 1949 , and that death occurred at 6:30 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE W. E. Handley M.D.				23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 4/25/49	
24a. BURIAL (If removed, specify)		24b. DATE 4/27-49		24c. NAME OF CEMETERY OR CREMATORY Niangua		24d. LOCATION (City, town, or county) (State) Niangua, Mo.	
DATE REC'D BY LOCAL REG. 4/27/49		REGISTRAR'S SIGNATURE W. E. Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Key Kainey Marshfield, Mo.			

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.....

Licensed Embalmer No. 3317

P. O. Address Newark, N.J.

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.