

FILED APR 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12234

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 4231 Registrar's No. 10

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

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mtn View, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mountain View, Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u> b. (Middle) <u>Francis</u> c. (Last) <u>Small</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 28 1949</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept, 8 1876</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Joseph Leech</u>	13b. MOTHER'S MAIDEN NAME <u>Ingram</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Small</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>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Small, Mountain View, Mo</u>	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute aden of chief</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial degeneration.</u> DUE TO (c) <u>Phylogenetic Kidney</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obese of entire body</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	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 Mar 3, 1949, to Mar 28, 1949, that I last saw the deceased alive on Mar 27, 1949 and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James R. Shepperd M.D.</u>	23b. ADDRESS <u>Mountain View Mo</u>	23c. DATE SIGNED <u>4/5/49</u>
---	---	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 30 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mountain View, Mo</u>	24d. LOCATION (City, town, or county) (State) <u>Mtn View, Mo</u>
--	---------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>4-6-49</u>	REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Duncan funeral Home</u>	ADDRESS <u>Mountain View Mo</u>
---	--	--	------------------------------------

RECEIVED

District Health Officer, Div. 5,

District File Number 449276

Date Filed 4-12-49

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..... *John F. Lennan*

Signed.....
Student Embalmer

Licensed Embalmer No. 2516

P. O. Address Atu View Ma

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.