

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

15490

State File No. _____

FILED JUN 6 1949

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>4469</u>	
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>Vernon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>12 hours</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Nevada</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Johns</u>				d. STREET ADDRESS (If rural, give location) <u>307 E Ashland</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ophelia</u>		b. (Middle) <u>Rabon</u>		c. (Last) <u>Albert</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 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>May 29, 1879</u>		9. AGE (In years last birthday) <u>69</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 MRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Rabon</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Everett B Albert, Springfield, Missouri</u>			
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) <u>cerebral thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3 3/4 X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</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?			
22. I hereby certify that I attended the deceased from <u>5/27, 1949</u> , to <u>6/27, 1949</u> , that I last saw the deceased alive on <u>5/27, 1949</u> and that death occurred at <u>10:45 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Glenn O. Turner, M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>5/31/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 28, 1949</u>		24c. NAME OF CEMETERY OR CREMATORIO <u>Nevada Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Nevada, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>6/2/49</u>		REGISTRAR'S SIGNATURE <u>W.S. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeyer</u>		ADDRESS <u>F.H. Springfield, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 27 1950

JUN 7 1945

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.....
Student Embalmer

Signed

Licensed Embalmer No. 2831

P. O. Address Springfield

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.