No. 300
10-48

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16458

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 5644 Registrar's No. 41

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

1. PLACE OF DEATH
a. COUNTY: LAFAYETTE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): DOVER
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RURAL

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

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3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): ANN
c. (Last): WILLARD

4. DATE OF DEATH (Month) 4 (Day) 9 (Year) 1949

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: 6/22/1868
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months 9, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NOT KNOWN 9
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: NOT KNOWN
13b. MOTHER'S MAIDEN NAME: NOT KNOWN
14. NAME OF HUSBAND OR WIFE: NOT KNOWN

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) Carcinoma of Stomach — 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.

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19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
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* 11/15, 1948 *to* 4/9, 1949 *that I last saw the deceased alive on* 4/9, 1949, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Geo. Jones DVD
23b. ADDRESS: Waverly
23c. DATE SIGNED: 4/10/49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 4/11/49
24c. NAME OF CEMETERY OR CREMATORY: DOVER CEM.
24d. LOCATION (City, town, or county) (State): DOVER MO.

DATE REC'D BY LOCAL REG.: 5/12/49
REGISTRAR'S SIGNATURE: Minerva [illegible] 15
25. FUNERAL DIRECTOR'S SIGNATURE: FORREST F. TEMPEL
ADDRESS: LEX. MO

(Licensed Embalmer's Statement on Reverse Side)

Rec. MAY 14

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 5-14-49

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 Geo. M. Kean

Licensed Embalmer No. 2983

P. O. Address Lexington 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.