

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19026

BIRTH NO. _____ **REG. DIST. NO.** 93 **PRIMARY REG. DIST. NO.** 5345 **Registrar's No.** 50

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Greenfield Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Greenfield Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If rural, give location) <u>Sal Turp</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Otis</u> b. (Middle) <u>Malone</u> c. (Last) <u>Divine</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 1 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. 2, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Dade Co Mo.</u>
13a. FATHER'S NAME <u>Radford C. Divine</u>		13b. MOTHER'S MAIDEN NAME <u>Phrana Russell</u>	14. NAME OF HUSBAND OR WIFE <u>Josephine Divine</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Josephine Divine</u> ADDRESS <u>Greenfield R?F?D</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11.3X</u>
ANTECEDENT CAUSES Morbidity 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.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:45 A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>St O Cowan M.D.</u>		23b. ADDRESS <u>Greenfield</u>	23c. DATE SIGNED <u>7-2-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 3, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>	24d. LOCATION (City, town, or county) (State) <u>Greenfield Mo</u>
DATE REC'D BY LOCAL REG. <u>7-3-49</u>	REGISTRAR'S SIGNATURE <u>Geo. L. Weir</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Allison</u> ADDRESS <u>Greenfield Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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9

RECEIVED
District Health Officer No. 6,
District File Number 749-812
Date Filed 2-11-49

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 W.R. Allison.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4404

P. O. Address Greenfield, 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.