

FILED AUG 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23119
Registrar's No. 663

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 1128 W. UNIVERSITY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY GREENE
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD 39
d. STREET ADDRESS (If rural, give location) 1128 W. UNIVERSITY 2

3. NAME OF DECEASED
a. (First) EFFIE b. (Middle) MCE c. (Last) MINCKS

4. DATE OF DEATH (Month) (Day) (Year) July 24 1949

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH SEPT 22, 1897

9. AGE (In years) (Months) (Days) (If under 1 year: Year Days Hours Min.) 51 9 2 1:30 PM

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK

11. BIRTHPLACE (State or foreign country) CHRISTIAN CO. MO.

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME THOMAS J. GRAY

13b. MOTHER'S MAIDEN NAME MERTHE BUTLER

14. NAME OF HUSBAND OR WIFE ROY MINCKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY NO. none

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS FLORENCE M. JONES

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Liver (Primary)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) none
DUE TO (c) none
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH
55 X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION none

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Springfield Greene Mo.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) none

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 12-12-1948 to 7-24-1949, that I last saw the deceased alive on 7-23-1949, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lyle B. Albright M.D.

23b. ADDRESS 319 1/2 E Walnut

23c. DATE SIGNED 7-26-49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 7/26/49

24c. NAME OF CEMETERY OR CREMATORY PALMETTO

24d. LOCATION (City, town, or county) (State) ROGERSVILLE 7710 ROR-MO

DATE REC'D BY LOCAL REG. 7-27-49

REGISTRAR'S SIGNATURE W.S. Handley M.D.

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS KELLEY FERRILL, BERGMAN ROGERSVILLE, MO

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

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 *H. K. Kelley*.....

Licensed Embalmer No. *3334*.....

P. O. Address *Fairland no*.....

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.