

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23140**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **631**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cedar	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) 0	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Stockton, Mo. R.R. #1	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Springfield Baptist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ona b. (Middle) Adama c. (Last) Simmons			4. DATE OF DEATH (Month) (Day) (Year) 7 16 49		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 13, 1870	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Cedar County	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME W. T. Kennedy	13b. MOTHER'S MAIDEN NAME ?	14. NAME OF HUSBAND OR WIFE Widowed
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mabel Hampton ADDRESS Springfield, Mo. 510 W. Chestnut
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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) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 42 2
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis generalised		
		DUE TO (c) Cachexia		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 **20 June, 1949**, to **15 July, 1949**, that I last saw the deceased alive on **7-16, 1949**, and that death occurred at **1:05 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Stanley A. Peterson (Degree or title) M.D.	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 15 July 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-17-49	24c. NAME OF CEMETERY OR CREMATORY Alder Cemetery	24d. LOCATION (City, town, or county) (State) Cedar County, Mo
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DATE REC'D BY LOCAL REG. 7-18-49	REGISTRAR'S SIGNATURE W. S. Landry	25. FUNERAL DIRECTOR'S SIGNATURE John A. Cantlon ADDRESS Stockton, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

130
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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 A. Cantlon

Signed.....
Student Embalmer

Licensed Embalmer No. *4387*

P. O. Address *Stockton, Md.*

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.