

FILED AUG 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25848

103

BIRTH NO. _____ REG. DIST. NO. 354 PRIMARY REG. DIST. NO. 6199 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Rhode Island</u> b. COUNTY <u>490</u>	
b. CITY OR TOWN <u>Clinton Twp</u> c. LENGTH OF STAY (in this place) <u>1 mo.</u>		c. CITY OR TOWN <u>Providence</u> d. STREET ADDRESS <u>2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED a. (First) <u>ANNA</u> b. (Middle) <u>MATILDA</u> c. (Last) <u>OTTO</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 16 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>Nov 12 1890</u>
9. AGE (In years last birthday) <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>4</u>	
13a. FATHER'S NAME <u>Brown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Frank Otto</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Florence Pierson Jones, mo</u>		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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>Clinton Twp, Texas, mo</u>			
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>4 a.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Gaynell Cunningham</u> (Degree or title) <u>Crown</u>		23b. ADDRESS <u>Cabool mo</u>	
23c. DATE SIGNED <u>July 16/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>July 18 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Providence Rhode</u>	
DATE REC'D BY LOCAL REG. <u>7-19-49</u>		REGISTRAR'S SIGNATURE <u>Gaynell Cunningham</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Gaynell H. Elliott</u>		ADDRESS <u>Cabool, mo.</u>	

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

Received
The [unclear]
7-26-
9:00

AUG 2 1919

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.....

Licensed Embalmer No.....

P. O. Address.....

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.