

FILED AUG 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26046

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>11</u>		PRIMARY REG. DIST. NO. <u>4024</u>		Registrar's No. <u>56</u>	
1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Barry</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cassville</u>		c. LENGTH OF STAY (in this place) <u>25 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cassville</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1003 Harold St.</u>				d. STREET ADDRESS (If rural, give location) <u>1003 Harold St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josie</u> b. (Middle) <u>Turner</u> c. (Last) <u>Mitts</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 3, 1949</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 19, 1886</u>		9. AGE (In years) (Last birthday) <u>62</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 MTH. Hours _____ Min. _____
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>Benton Co., Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Sterlin David</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia E.</u>		14. NAME OF HUSBAND OR WIFE <u>William Henry Mitts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ruby Marshall, Cassville, Mo.</u>			
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) <u>arterio Sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>I do not know.</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.  <u>4211</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)			
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 <u>May</u> , 1949, to <u>Aug 2</u> , 1949, that I last saw the deceased alive on <u>Aug 2</u> , 1949, and that death occurred at <u>9 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Deedee or title) <u>Dermott T. Dalyer M. D.</u>				23b. ADDRESS <u>Cassville Mo</u>		23c. DATE SIGNED <u>Aug 8</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-7-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Horner Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Barry County, Mo.</u>		
DATE RECD. BY LOCAL REG. <u>Aug 8 1949</u>		REGISTRAR'S SIGNATURE <u>Grace Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Koon</u>		ADDRESS <u>Cassville, Mo.</u>	

RECEIVED AUG 15 1949  
District Health Office No. 6,  
District File Number 849-941  
Date Filed 8-18-49

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 W. C. Koon

Licensed Embalmer No. 4359

P. O. Address Cassville, 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.