

FILED AUG 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26622**

BIRTH NO. _____		REG. DIST. NO. <b>128</b>		PRIMARY REG. DIST. NO. <b>2000</b>		Registrar's No. <b>768</b>	
1. PLACE OF DEATH a. COUNTY <b>greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. LENGTH OF STAY (in this place) <b>26 Yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns</b>				d. STREET ADDRESS (If rural, give location) <b>840 S. Kansas,</b>			
3. NAME OF DECEASED a. (First) <b>Nancy</b>		b. (Middle) <b>Ellen</b>		c. (Last) <b>Hawes</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 24, 1949</b>	
5. SEX <b>F M</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec. 4th, 1869</b>	
9. AGE (In years last birthday) <b>79</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Ozark, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Isham Handy</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Wray</b>		14. NAME OF HUSBAND OR WIFE <b>John Buck Wray</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Miss Mamie Hawes, 840 S. Kansas, City</b>			
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) <b>Pulmonary edema</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cardiac decompensation</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Anaxarea</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>3 yrs</b> <b>2 yrs</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>None</b>				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) <b>Springfield Greene, Mo.</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4200</b>			
22. I hereby certify that I attended the deceased from <b>Nov 15, 1947</b> to <b>Aug 24, 1949</b> , that I last saw the deceased alive on <b>Aug 23, 1949</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE <b>[Signature]</b> (Degree by title)				23b. ADDRESS <b>609 Cherry St. Spfld. Mo.</b>		23c. DATE SIGNED <b>Aug 27, 49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-28, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>		24d. LOCATION (City, town, or county) (State) <b>Near Ozark, Mo.</b>	
DATE REC'D BY LOCAL <b>8-26-49</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Springfield, Mo.</b>			

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.

Signed A. S. McCann

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2727

P. O. Address. Springfield 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.