

THE DIVISION OF HEALTH OF MISSOURI
 FILED SEP 15 1949 STANDARD CERTIFICATE OF DEATH

27162

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 154

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>	
c. LENGTH OF STAY (In this place) <u>32yrs</u>		d. STREET ADDRESS (If rural, give location) <u>1827 S. Garrison</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mc Cune Brooks Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Lydia Carolyn</u>	b. (Middle) <u>Izard</u>	c. (Last) <u>Izard</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 2 1949</u>
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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>9-7-88</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
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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 <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Chetopa Kans.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Wm. Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Evans</u>	14. NAME OF HUSBAND OR WIFE <u>Mark W. Izard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mark W. Izard, Carthage, Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis, Chronic</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>interstitial</u> DUE TO (c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		4222	

19a. DATE OF OPERATION <u>None</u>	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) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 14 '48, 19, to Sept 2, 1949, that I last saw the deceased alive on Sept 2, 1949, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George H. Weed M.D.</u>	23b. ADDRESS <u>Carthage Mo</u>	23c. DATE SIGNED <u>Sept 3 '49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>9-5-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>	24d. LOCATION (City, town, or County) (State) <u>Van Buren, Arkansas</u>
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DATE REC'D BY LOCAL REG. <u>9-6-1949</u>	REGISTRAR'S SIGNATURE <u>L. B. Clinton, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ulmer Funeral Home, Carthage</u>
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Reg. n. Ferguson, Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-12-49
Jasper County Health Office

County File Number 49-8-691
Date Filed 9-13-49

OCT 13 1949

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 Donald L Roberts

Licensed Embalmer No. 4722

P. O. Address Casthage N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.