

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27622**

FILED AUG 18 1949

BIRTH NO. _____		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 5922		Registrar's No. 266	
1. PLACE OF DEATH a. COUNTY Pettis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pettis			
b. CITY (If outside corporate limits, write RURAL and give township) Sedalia Bowling Green		c. LENGTH OF STAY (in this place) 1		c. CITY (If outside corporate limits, write RURAL and give township) Sedalia Bowling Green		d. STREET ADDRESS (If rural, give location) Rural P. # 5	
d. FULL NAME OF HOSPITAL OR INSTITUTION R.F.D. # 5							
3. NAME OF DECEASED (Type or Print) a. (First) NANCY			b. (Middle) JANE		c. (Last) SPAITS		4. DATE OF DEATH (Month) (Day) (Year) Aug-4-1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Nov-3-1863		9. AGE (In years last birthday) 85 if under 1 year: Months 9 Days 1 if under 12 hrs: Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home-maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maine Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Charles Spaits			13b. MOTHER'S MAIDEN NAME Katherine Nicholas		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Miss Myrtle Spaits		ADDRESS Kansas City Mo	
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) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 5 days 331X	
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) 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 5 July, 1949 , to 4 Aug, 1949 , that I last saw the deceased alive on 3 Aug, 1949 , and that death occurred at 2:50 AM , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) P. Siegel M.D.				23b. ADDRESS Smithton Mo		23c. DATE SIGNED 5 Aug 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-6-49		24c. NAME OF CEMETERY OR CREMATORY Smithton cem - Smithton		24d. LOCATION (City, town, or county) (State) Smithton Mo	
DATE REC'D BY LOCAL REG. 8-6-49		REGISTRAR'S SIGNATURE Betty Yeager		25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Bros		ADDRESS Sedalia Mo	

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

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c
d

RECEIVED AUG 8
District Health Officer No. 8,
District File Number _____
Date Filed 8-17-19

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 K.P.M. Lary

Signed _____
Student Embalmer

Licensed Embalmer No. 3153

P. O. Address Sedalia

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.