

Dr. Tillman  
FILED NOV 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33613

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>983</u>	
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) OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (in this place) <b>22 Yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		39 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baptist</b>				d. STREET ADDRESS (If rural, give location) <b>2121 West Olive</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Artelia</b> b. (Middle) <b>Elizabeth</b> c. (Last) <b>Tella</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 8, 1949</b>				
5. SEX <b>F M</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Apr. 1, 1875</b>	
9. AGE (In years, last birthday) <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Christian Co., Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George Hargis</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>		14. NAME OF HUSBAND OR WIFE <b>Wm. F. Tella (Deceased)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Everett Burks, 811 W. Monroe Ter.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac failure</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Unknown</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <b>45 hrs</b>  <b>4543</b>
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)			
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 <u>Nov. 7, 1949</u> , to <u>Nov. 8, 1949</u> , that I last saw the deceased alive on <u>Nov. 8, 1949</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>W. W. Tillman, M.D.</b>				23b. ADDRESS <b>Citizens Bank Bldg. Springfield, Mo.</b>		23c. DATE SIGNED <b>11-10-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Nov. 11 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>West Finley</b>		24d. LOCATION (City, town, or county) (State) <b>Near Rogersville, Mo.</b>		
DATE REC'D BY LOCAL REG <b>11-10-49</b>		REGISTRAR'S SIGNATURE <b>W. E. Handley M.D.</b>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. L. Luman Springfield, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....  
Student Embalmer

Signed *H. J. McCann*

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.