

FILED OCT. 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34282

BIRTH NO. _____ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 3036 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Aurora</u>	c. LENGTH OF STAY (in this place) township) <u>1</u> <u>6 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Crane</u> <u>104</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Aurora Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>9</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ida</u> b. (Middle) <u>Emeline</u> c. (Last) <u>Kelley</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 7, 1949</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 11, 1862</u>	9. AGE (In years last birthday) <u>86</u>	# UNDER 1 YEAR Months <u>10</u> Days <u>26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Athens Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Andrew Jackson Howard</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Howard</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Mary Kelley</u>	
				ADDRESS <u>Crane, 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture of r. hip.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Renal hypertension.</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SOURCE HOMEHIDE (Specify) <u>accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Stone Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-1-49</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell from front door step</u>

22. I hereby certify that I attended the deceased from Oct-1, 1949, to Oct-7, 1949, that I last saw the deceased alive on Oct-7, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. P. Lopez</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Aurora, Mo.</u>	23c. DATE SIGNED <u>10-8-49</u>
--------------------------------------	----------------------------------	------------------------------------	------------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Oct. 9, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Old Town Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Crane, Mo.</u>
---	----------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>Oct 8/49</u>	REGISTRAR'S SIGNATURE <u>Ora Mc Nott</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Maulon</u>	ADDRESS <u>Crane Mo</u>
---	---	---	----------------------------

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

55

RECEIVED OCT 19 1949
District Health Office No. 6,
District File Number 1049-1121
Date Filed 10-21-49

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.

Signed Herman Lussis

Signed _____
Student Embalmer

Licensed Embalmer No. 3072

P. O. Address Marionville

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.