

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **36904**

FILED NOV 21 1949

REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1005**

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

1- PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Webster	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Rogersville	
c. LENGTH OF STAY (in this place) 0		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		d. STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print) a. (First) Addie b. (Middle) Vesta c. (Last) HOLLAND		4. DATE OF DEATH (Month) (Day) (Year) Nov. 15 1949	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Sept. 30, 1875
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Knoxville, Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W. Jones	
13b. MOTHER'S MAIDEN NAME ELIZA C. VAN D		14. NAME OF HUSBAND OR WIFE JAMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
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.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Audie G. Fipplet ADDRESS Rogersville Mo	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
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)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		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)		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 Nov 15, 1949 , to Nov 15, 1949 , that I last saw the deceased alive on Nov 10, 1949 , and that death occurred at 8 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Wesley W. D. O. (Degree or title)		23b. ADDRESS Springfield Mo	
23c. DATE SIGNED Nov 15/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov. 17-49	
24c. NAME OF CEMETERY OR CREMATORY Holland Cemetery		24d. LOCATION (City, town, or county) (State) Rogersville Rural, Mo	
DATE REC'D BY LOCAL REG. 11-17-49		REGISTRAR'S SIGNATURE W.S. Haulsley	
25. FUNERAL DIRECTOR'S SIGNATURE W. Kelley-Foxwell-Berlman		ADDRESS Rogersville Mo	

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. K. Kelley

Signed _____
Student Embalmer

Licensed Embalmer No. 3334

P. O. Address Fordland 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.