

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH41922
State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>265</u>		PRIMARY REG. DIST. NO. <u>5889</u>		Registrar's No. <u>13</u>	
1. PLACE OF DEATH a. COUNTY <u>Ozark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ozark</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Isabella, Mo. Jasper</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Isabella, Mo. Jasper</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ozark Co. Jasper Township</u>				d. STREET ADDRESS (If rural, give location) <u>Town Of Isabella, Mo</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Zella</u> b. (Middle) <u>Hale</u> c. (Last) <u>Hale</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 30, 1949</u>			
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>Sept. 21, 1885</u>	
9. AGE (In years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>State of Mo. Christian Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Hiram Weston</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Todd</u>		14. NAME OF HUSBAND OR WIFE <u>Rev. James F. Hale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Rev. J.F. Hale, Isabella, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial Failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Auricular Fibrillation</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension 210/150</u>			
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) (Min.)		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. 29, 1949</u> , to <u>Nov 30, 1949</u> , that I last saw the deceased alive on <u>Nov 30, 1949</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M.C. Gentry D.M.S.</u>				23b. ADDRESS <u>Box 110</u>		23c. DATE SIGNED <u>12-4-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec-3-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Isabella Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Isabella, Mo. Ozark Co.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 7, 49</u>		REGISTRAR'S SIGNATURE <u>Maie Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Blunkingbeard Funeral Home, Danville Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DEC 13 1949

District Health Office No. 6,

District File Number 1249-1342

Date Filed 12-24-49

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 _____

working under my personal supervision. _____ Student Embalmer No. _____

Student
Student Embalmer

Signed

Chester A. R. ...

Licensed Embalmer No. 3044

P. O. Address Gainesville, 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.