

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

647

State File No.

BIRTH NO. Jan. 10-50 REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4153 Registrar's No. 3

0290

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

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived: "If institution; residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood</u>	c. LENGTH OF STAY (In this place) <u>5WKS</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Ceder Twp.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>Lockwood R.F.D.#2</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Myrtle</u>	b. (Middle) <u>May</u>	c. (Last) <u>Mitchell</u>	Jan	7	1950

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 3 1891</u>		9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Dade Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John Cowan</u>	13b. MOTHER'S MAIDEN NAME <u>Lillie Belknap</u>	14. NAME OF HUSBAND OR WIFE <u>Elezie W. Mitchell</u>	
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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 ADDRESS <u>John O. Mitchell Lockwood R#2 Mo</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cardiac De compensation</u>		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) <u>Bronchiectasis</u>		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>526X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR.	
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22. I hereby certify that I attended the deceased from Nov 29th, 1949, to Jan. 6th, 1950, that I last saw the deceased alive on Jan. 6th, 1950, and that death occurred at 1:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Max Hilburn M.D.</u>	23b. ADDRESS <u>Lockwood, Mo</u>	23c. DATE SIGNED <u>1-7-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial #1</u>	24b. DATE <u>Jan. 9, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Collins Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Dade Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>1-10-50</u>	REGISTRAR'S SIGNATURE <u>Leo K. Weir 79</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.R. Allison Greenfield Mo.</u>	
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RECEIVED JAN 16 1950
District Health Office No. 6,
District File Number 150-102
Date Filed 1-19-50

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: W.R. Allison

Licensed Embalmer No. 44404

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.