

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Hanan

State File No. 886.5BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Carthage	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1833 E. Sunshine		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) a. (First) Lucinda Jane b. (Middle) Drake c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Jan. 13 1950		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Nov. 24, 1876		9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME W. H. Miller		13b. MOTHER'S MAIDEN NAME Anne Kitsmiller		14. NAME OF HUSBAND OR WIFE Sherman Drake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sherman Drake Springfield, Mo.	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		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) Chronic gallbladder disease			
		DUE TO (c) Cholelithiasis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				584X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)		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 1940, 19 , to Jan 13, 1950, that I last saw the deceased alive on Jan 12, 1950, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE E. R. Handley		(Degree or title)		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 1-11-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial #7		24b. DATE 1/15/50		24c. NAME OF CEMETERY OR CREMATORY Park		24d. LOCATION (City, town, or county) (State) Carthage, Mo.	

DATE REC'D BY LOCAL REG. 1-14-50		REGISTRAR'S SIGNATURE W. E. Handley MD III		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman Lohmeyer Springfield,	
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

Gene Schmeigel

Signed _____
Student Embalmer

Licensed Embalmer No. *4734*

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.