

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

1506

State File No. ....

FILED JAN 30 1950

|                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| BIRTH NO. ....                                                                                                                                                                                                                                                                    |  | REG. DIST. NO. <u>156</u>                                                                              |  | PRIMARY REG. DIST. NO. <u>200F</u>                                                                                                                                                                                                                                                                                                                                                 |  | Registrar's No. <u>10</u>                                                         |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jasper</u>                                                                                                                                                                                                                                      |  |                                                                                                        |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>                                                                                                                                                                                                                                          |  |                                                                                   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Joplin</u>                                                                                                                                                                                             |  | c. LENGTH OF STAY (in this place)<br>.....                                                             |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Joplin</u>                                                                                                                                                                                                                                                                                              |  | 495                                                                               |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>2217 Moffot Ave.</u>                                                                                                                                                                                                                |  |                                                                                                        |  | d. STREET ADDRESS (If rural, give location)<br><u>2217 Moffot</u>                                                                                                                                                                                                                                                                                                                  |  |                                                                                   |  |
| 3. NAME OF DECEASED (Type or Print)<br><u>Laura Ida Alexander</u>                                                                                                                                                                                                                 |  | a. (First)                                                                                             |  | b. (Middle)                                                                                                                                                                                                                                                                                                                                                                        |  | c. (Last)                                                                         |  |
| 4. DATE OF DEATH<br><u>1-6-50</u>                                                                                                                                                                                                                                                 |  | 5. SEX<br><u>F.</u>                                                                                    |  | 6. COLOR OR RACE<br><u>W</u>                                                                                                                                                                                                                                                                                                                                                       |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>          |  |
| 8. DATE OF BIRTH<br><u>2-14-1890</u>                                                                                                                                                                                                                                              |  | 9. AGE (In years last birthday)<br><u>59</u>                                                           |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><u>Ill.</u>                          |  |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                      |  | 13a. FATHER'S NAME<br><u>Edward F. Lacey</u>                                                           |  | 13b. MOTHER'S MAIDEN NAME<br><u>Anna Sportosman</u>                                                                                                                                                                                                                                                                                                                                |  | 14. NAME OF HUSBAND OR WIFE<br><u>William Alexander</u>                           |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)<br><u>No</u>                                                                                                                                                                                                         |  | 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                 |  | 17. INFORMANT'S SIGNATURE OR NAME<br><u>William Alexander</u>                                                                                                                                                                                                                                                                                                                      |  | ADDRESS                                                                           |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the cause of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                                    |  |                                                                                                        |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure inoma</u><br><br>ANTECEDENT CAUSES<br>DUE TO (b) <u>Metastatic Carcinoma Tubes</u><br><u>Carcinoma Fallopian Tubes</u><br>DUE TO (c)<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |                                                                                   |  |
| 19a. DATE OF OPERATION<br><u>7-21-48</u>                                                                                                                                                                                                                                          |  | 19b. MAJOR FINDINGS OF OPERATION<br><u>Adenocarcinoma fallopian tubes</u>                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>8/2/49</u><br><u>1/6/50</u><br><u>175X</u> |  |
| 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) m.                                                                                                                                                                                                                                |  | 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>7/20</u> , 19 <u>48</u> , to <u>1/6/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>50</u> , and that death occurred at <u>.....</u> m., from the causes and on the date stated above. |  |                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                   |  |
| 23a. SIGNATURE (Degree or title)<br><u>W. E. Heinlen, M.D.</u>                                                                                                                                                                                                                    |  |                                                                                                        |  | 23b. ADDRESS<br><u>Joplin</u>                                                                                                                                                                                                                                                                                                                                                      |  | 23c. DATE SIGNED<br><u>1-9-50</u>                                                 |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>                                                                                                                                                                                                                       |  | 24b. DATE<br><u>1-9-50</u>                                                                             |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Hill</u>                                                                                                                                                                                                                                                                                                                              |  | 24d. LOCATION (City, town, or county) (State)<br><u>Galena, Kansas</u>            |  |
| DATE REC'D BY LOCAL REG.<br><u>1-9-50</u>                                                                                                                                                                                                                                         |  | REGISTRAR'S SIGNATURE<br><u>W. E. Heinlen</u>                                                          |  | FUNERAL DIRECTOR'S SIGNATURE<br><u>William E. Robert</u>                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><u>Galena</u>                                                          |  |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr Highland Church Hosp

RECEIVED 1-17-50  
Jasper County Health Office

County File Number 50-1-20

Date Filed 1-24-50

Jan 30 1950

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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.

Student \_\_\_\_\_  
Student Embalmer

Signed

*Jesse O. Sullivan*

Licensed Embalmer No. 4646

P. O. Address *Jasper, 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.