

FILED MAR 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4045

0126

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

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 110

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural/..Gillis Bluff		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural.....Gillis Bluff	
d. FULL NAME OF HOSPITAL OR INSTITUTION 9 mi. South of Quilin, Mo		d. STREET ADDRESS (If rural, give location) 9 miles South of Quilin, Mo.	
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) H. c. (Last) SPROUTS			4. DATE OF DEATH (Month) (Day) (Year) 3/2/50
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 15, 1891
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days 9 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Dave Sprouts	
13b. MOTHER'S MAIDEN NAME Minnie.....		14. NAME OF HUSBAND OR WIFE Nellie Sprouts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Nellie Sprouts,.....		ADDRESS Quilin, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia ANTECEDENT CAUSES: chronic nephritis DUE TO (b) months DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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) Poplar Bluff Butler Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 25 1950		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 Feb 25, 1950 , to Feb 25, 1950 , that I last saw the deceased alive on Feb 25, 1950 , and that death occurred at 7 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Alfred R. Rowe M.D.		23b. ADDRESS Poplar Bluff Mo Mar 4-50	
23c. DATE SIGNED		23d. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/3/50	
24c. NAME OF CEMETERY OR CREMATORY Woodlawn		24d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo.	
DATE REC'D BY LOCAL REG. Mar 6-1950		REGISTRAR'S SIGNATURE Wm. H. Johnson	
25. FUNERAL DIRECTOR'S SIGNATURE Frank-Cotrell.....		ADDRESS Poplar Bluff, Mo.	

MAR 26 1950

350-123

BUTLER COUNTY HEALTH CENTER
POPLAR BLUFF, MISSOURI

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 _____

Licensed Embalmer No. 3567

P. O. Address Poplar Bluff, 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.