

FILED FEB 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4714

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>5551</u>		Registrar's No. <u>555</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Howell</u>		b. CITY (If outside corporate limits, write RURAL and give town or township) <u>WEST PLAINS RURAL</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Howell</u>	
c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains Mo 60</u>		d. STREET ADDRESS _____		(If rural, give location) <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>COUNTY FARM</u>							
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) <u>Anna</u>		b. (Middle) <u>Mc</u>	c. (Last) <u>Party</u>	(Month) <u>Feb</u>	(Day) <u>7</u>	(Year) <u>1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>Jan 1 1873</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 28 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>unk</u>		13b. MOTHER'S MAIDEN NAME <u>unk</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Elmer Eby</u> ADDRESS <u>WEST PLAINS MO</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Nephrositis, Chronic</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES <u>Arteriosclerosis</u>					
		MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS <u>Fract Lt Forearm (Colles)</u>					
		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) _____			
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 <u>Jan 18</u> , 19 <u>50</u> , to <u>Feb 7</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>50</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Beatrice Cook M.D.</u>				23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>7 Feb 50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7 Feb 50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>County Farm Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>West Plains, Mo</u>			
DATE REC'D BY LOCAL REG. <u>2-8-50</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u>		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 2/13/50  
District Health Officer No. 5,  
District File Number 260108  
Date Filed 2/17/50

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.

Signed.....  
..... Licensed Embalmer No.....  
Student Embalmer P. O. Address.....

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.