No. 300
10.48

FILED MAR 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8303

State File No.

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 275

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 535 E Tampa

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Greene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield
d. STREET ADDRESS (If rural, give location) 535 E Tampa

3. NAME OF DECEASED (Type or Print)
a. (First) Anna
b. (Middle) –
c. (Last) Hines

4. DATE OF DEATH (Month) (Day) (Year) 3-23-1950

5. SEX Female
6. COLOR OR RACE Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH July-24-1866
9. AGE (In years last birthday) 83 — If under 1 year: Months 7 Days 29 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Tishie Pate
14. NAME OF HUSBAND OR WIFE Unknown - widowed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) –
(If yes, give war or dates of service) –
16. SOCIAL SECURITY NO. –
17. INFORMANT'S SIGNATURE OR NAME Walter Shearron — **ADDRESS** 535 E Tampa

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) Acute Myocardial Insufficiency — 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)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec —, 1947, to Mar 23, 1950, that I last saw the deceased alive on Mar 21, 1950, and that death occurred at 10:15 P m., from the causes and on the date stated above.

23a. SIGNATURE Lyman H. Brown (Degree or title) M.D.
23b. ADDRESS 311½ Boonville
23c. DATE SIGNED Mar 24, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3-26-1950
24c. NAME OF CEMETERY OR CREMATORY Hazelwood Cem.
24d. LOCATION (City, town, or county) Springfield (State) Mo

DATE REC'D BY LOCAL REG. 3-25-50
REGISTRAR'S SIGNATURE M. Handley MD
25. FUNERAL DIRECTOR'S SIGNATURE W P Campbell — **ADDRESS** Springfield Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 N. P. Campbell

Signed .....
Student Embalmer

Licensed Embalmer No. 1747

P. O. Address Springfield N

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.