

FILED MAY 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12795
State File No.

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5551 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains, Mo.</u>	
c. LENGTH OF STAY (in this place) <u>3 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>Rt # 2</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) <u>Leah</u> b. (Middle) <u>Mae</u> c. (Last) <u>Hebb</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-2-1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wht</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>Jan 25, 1917</u>
9. AGE (In years last birthday) <u>33</u>	IF UNDER 1 YEAR Days <u>7</u>	IF UNDER 12 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Howell Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <u>H. L. Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Leah Russell</u>	14. NAME OF HUSBAND OR WIFE <u>Olney Hebb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Olney Hebb, West Plains, Mo. Rt # 2</u>	
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) <u>Carcinoma of Colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>with metastases</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Intestinal Obstruction</u>	
19a. DATE OF OPERATION <u>7-20-49</u> <u>7-30-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of colon - wide abdominal metastases</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE <u>10-2-1949 (Specify)</u>	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>2-2</u> , 19 <u>50</u> , and that death occurred at <u>12:27 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>E. C. Bohrer, M.D.</u>		23b. ADDRESS <u>West Plains, Mo</u>	23c. DATE SIGNED <u>2-15-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	24b. DATE <u>2-4-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Pease Valley Mo</u>
DATE REC'D BY LOCAL REG. <u>4/24/50</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> 379	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robertson West Plains, Mo</u>	

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

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RECEIVED

5-1-50

District Health Officer No. 5,

District File Number

5-50 258

Date Filed

5-2-50

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.

Student _____
Student Embalmer

Signed

Robert L. Mayo

Licensed Embalmer No.

4547

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.