

FILED APR 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15580

BIRTH NO. _____ REG. DIST. NO. 236 PRIMARY REG. DIST. NO. 6136 Registrar's No. 517

1. PLACE OF DEATH a. COUNTY Shannon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Shannon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Summersville	c. LENGTH OF STAY (in this place) 80 years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Summersville SP VALLEY	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) route #3 4MI SE Summersville	
3. NAME OF DECEASED (Type or Print) ED	a. (First)	b. (Middle) ALUMBAUGH	c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) Feb 10-1950		5. SEX M	
6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH April 28-1862	9. AGE (In years last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) indiana /	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Sarah Alumbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS O.L. Alumbaugh 828 Shawnee Rd KC Kn.	
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, athenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c) arterial Hypertension 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 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</u> , 19 <u>48</u> , to <u>Feb 10</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>50</u> , and that death occurred at <u>2:40a</u> m., from the causes and on the date stated above.
23a. SIGNATURE (Degree or title) Dr. Hadere Hampton D.O.	23b. ADDRESS Summersville	23c. DATE SIGNED Mar 31	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/8/50	24c. NAME OF CEMETERY OR CREMATORY Oak Side	24d. LOCATION (City, town, or county) (State) mtn view, mo.
DATE REC'D BY LOCAL REG. 4/8/50	REGISTRAR'S SIGNATURE H. H. Ballinger	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS uncan funeral Home mtn view, Mo.	

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

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RECEIVED

4-11-50

District Health Officer No. 5,

District File No.

450234

Date Filed

4-13-50

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

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....
Joe R. Brennan
Licensed Embalmer No. 4826

P. O. Address Montclair Ave

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.