

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16490**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **536**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	d. STREET ADDRESS (If rural, give location) 1007 W. STATE
d. FULL NAME OF HOSPITAL OR INSTITUTION 1007 W. STATE			

3. NAME OF DECEASED (Type or Print) ETHEL			a. (First)			b. (Middle)			c. (Last) STONE			4. DATE OF DEATH JUNE 9 1950		

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 4 DEC. 1865	9. AGE (In years last birthday) 84	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IN HOME	11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME HENRY HARRIS		13b. MOTHER'S MAIDEN NAME MARY POSEY		14. NAME OF HUSBAND OR WIFE DECEASED	
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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. NO	17. INFORMANT'S SIGNATURE OR NAME E.L. HARRIS		ADDRESS SPGFD. MO.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal Vascular Disease				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES	DUE TO (b)	DUE TO (c)	
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
	II. OTHER SIGNIFICANT CONDITIONS			
	Conditions contributing to the death but not related to the disease or condition causing death.			4/2X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)
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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
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22. I hereby certify that I attended the deceased from **June 2, 1949** to **June 9, 1950**, that I last saw the deceased alive on **June 9, 1950**, and that death occurred at **3:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Mary Ethel Stone	(Degree or title) M.D.	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 6-10-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12 JUNE 1950	24c. NAME OF CEMETERY OR CREMATORY LAMONTE CEMETERY	24d. LOCATION (City, town, or county) (State) NEAR SEDALIA MO.
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DATE REC'D BY LOCAL REG. 6-10-50	REGISTRAR'S SIGNATURE W.E. Handley, Jr. D.O.	25. FUNERAL DIRECTOR'S SIGNATURE F. W. Klingner & Co.	ADDRESS Spfgd. Mo.
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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.....
Student Embalmer

Signed .....
Licensed Embalmer No. 3358

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.