S. No. 300
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FILED MAY 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16514

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 3466 Registrar's No. 438

1. PLACE OF DEATH
a. COUNTY: GREENE
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: SPRINGFIELD — RURAL - 3RD N. CAMPBELL
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): COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: GREENE
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: STRAFFORD, MO 0379
d. STREET ADDRESS (If rural, give location): JACKSON TWP. STRAFFORD, MO.

3. NAME OF DECEASED (Type or Print): a. (First) RUFUS b. (Middle) W. c. (Last) LINDSEY
4. DATE OF DEATH (Month) (Day) (Year): MAY 6 1950
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): 82 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): UNKNOWN 9
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: UNKNOWN
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: SINGLE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ??
17. INFORMANT'S SIGNATURE OR NAME: GEO. WHITE ADDRESS: STRAFFORD, MO.

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — 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) Arteriosclerosis, Cerebral
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* April 26, 1950, *to* May 6, 1950, *that I last saw the deceased alive on* May 3, 1950 *and that death occurred at* 11:20 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE: James R Amos (Degree or Title) M.D.
23b. ADDRESS: Springfield, Mo.
23c. DATE SIGNED: 5/9/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May - 9 - 50
24c. NAME OF CEMETERY OR CREMATORY: Caldwell Cem.
24d. LOCATION (City, town, or county) (State): Strafford, Mo.

DATE REC'D BY LOCAL REG.: 5-9-50
REGISTRAR'S SIGNATURE: N. E. Handley M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: G. W. Klingner & Co. Spgfd.
ADDRESS:

(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.

Student .....
Student Embalmer

Signed Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.