FILED MAY 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16604

BIRTH NO. _____ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 5556 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn View Rural
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) Galdsberry Trip

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY Howell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn View R. 0460
d. STREET ADDRESS (If rural, give location) N-Mtn View - 2½ mi

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Marrion c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) May 9 - 1950

5. SEX M 0
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 2
8. DATE OF BIRTH Sept 1 - 1872
9. AGE (In years last birthday) 78 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) Old age pension
10b. KIND OF BUSINESS OR INDUSTRY No industry
11. BIRTHPLACE (State or foreign country) Boonville Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME John Smith
13b. MOTHER'S MAIDEN NAME unk
14. NAME OF HUSBAND OR WIFE

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 ADDRESS Cauntz Farm West Plains Mo

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) Congestive Heart Failure

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.

INTERVAL BETWEEN ONSET AND DEATH

4343

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* Sept, 1949, *to* May 8, 1950, *that I last saw the deceased alive on* May 8, 1950, *and that death occurred at* 3A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Stanley Barnum D.O.
23b. ADDRESS Mountain View, Mo
23c. DATE SIGNED 5-16-50

24a. BURIAL, CREMATION, REMOVAL (Specify) B 0
24b. DATE May 10 - 50
24c. NAME OF CEMETERY OR CREMATORY Howell Co cemetery
24d. LOCATION (City, town, or county) West Plains (State) Mo

DATE REC'D BY LOCAL REG. 5/16/50
REGISTRAR'S SIGNATURE Laura Mitchell 126 0
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS No Funeral Director.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 5-18-50
District Health Officer No. 5,
District File Number 550305
Date Filed 5-19-50

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.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.