

FILED JUL 10 1950

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>608</u>			
1. PLACE OF DEATH a. COUNTY <u>GREEN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Douglas</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>8 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mansfield</u>		0341			
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>OZARK OSTEOPATHIC HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>Route # 2</u>					
3. NAME OF DECEASED (Type or Print) <u>Era Robert Aborn</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>7-4-50</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>8-5-1923</u>		9. AGE (In years last birthday) <u>26</u>	10. MONTHS <u>9</u>	11. IF UNDER 1 YEAR Days	12. IF UNDER 24 HRS. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Douglas Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Charles Aborn</u>			13b. MOTHER'S MAIDEN NAME <u>Elsie North</u>		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) <u>no</u>		16. SOCIAL SECURITY NO. <u>490-28-4493</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Charles Aborn</u>				ADDRESS <u>Mo 45, Mansfield, Mo.</u>	
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) <u>Cecheuxia</u>	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						163x		
*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 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Probably primary in liver</u>								
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) (Min.)		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>June 26, 1950</u> , to <u>July 4, 1950</u> that I last saw the deceased alive on <u>July 4, 1950</u> , and that death occurred at <u>11:30 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>R. C. Michael D.O.</u>				23b. ADDRESS <u>Springfield</u>			23c. DATE SIGNED <u>7/4/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial (1)</u>		24b. DATE <u>7-7-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Prairie Hollow Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>7 Mile S.E. Mansfield Mo</u>				
DATE REC'D BY LOCAL REG. <u>7-5-50</u>		REGISTRAR'S SIGNATURE <u>W. E. Landley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Kelley, Ferrell Bergman</u>		ADDRESS <u>Mansfield, Mo</u>			

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. 4594

P. O. Address Springfield, Mo.

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.