

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1950

State File No.

No. 300
10.48

390
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BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 555

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural-N. Campbell Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Taylor Twp</u> <u>0390</u>	
c. LENGTH OF STAY (in this place) <u>4 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>Route # 3 Rogersville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Greene County Farm</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Ella</u> c. (Last) <u>Hutchinson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 14, 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 5 1870</u>
9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>(Unknown) Hall</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>	
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>No</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ruth Fisher Strafford, Mo.</u>			
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) <u>Bronchopneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>fracture right hip</u> DUE TO (c) <u>arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>18 das.</u> <u>19030</u> <u>21</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION <u>6-1-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture right hip</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Rt # 3 Rogersville Greene Mo</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>5 28 50 3 in</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>	
22. I hereby certify that I attended the deceased from <u>6-6, 1950</u> , to <u>6-14, 1950</u> , that I last saw the deceased alive on <u>6-13, 1950</u> , and that death occurred at <u>2:20 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>James R. Christ MD</u>		23b. ADDRESS <u>Springfield</u>	
23c. DATE SIGNED <u>6-15-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>6/15/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ashland</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-15-50</u>		REGISTRAR'S SIGNATURE <u>W. H. Hurdley W.D.</u>	

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 *Gene Johnson*

Licensed Embalmer No. *4739*

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.