

FILED AUG 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22645

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>5004</u>		Registrar's No. <u>191</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Morrow</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Morrow</u>		<u>0010</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Home--6 mi. N.E. Green Castle</u>				d. STREET ADDRESS (If rural, give location) <u>6 mi NE of Green Castle, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Okel</u>		b. (Middle) <u>Calvin</u>		c. (Last) <u>Sizemore</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 13, 1950</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 26, 1900</u>	
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ 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>General Farming</u>			11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Calvin Sizemore</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Edith Sizemore</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>489-14-7714</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Edith Sizemore, Green Castle,</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>Bronchial Hemorrhage</u> ANTECEDENT CAUSES <u>Pulmonary Tuberculosis 4 yrs</u> 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. <u>002X</u>				19. INITIALS BETWEEN ONSET AND DEATH	
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)		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 1, 1950</u> to <u>July 13, 1950</u> , that I last saw the deceased alive on <u>July 1, 1950</u> , and that death occurred at <u>130 ft</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. D. Garrison M.D.</u>				23b. ADDRESS <u>Younger Mo</u>		23c. DATE SIGNED <u>7-14-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 15, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Morelock</u>		24d. LOCATION (City, town, or county) (State) <u>Adair County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-16-50</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glenn E. Kent &amp; Son, Green Castle, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

JUL 25 1958

District Health Officer No. 10

District File Number 7-50-1223

Date Filed JUL 1 1958

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

*Karl R. Fent*

Licensed Embalmer No. 4689

P. O. Address *Green City, 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.