

FILED AUG 7 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23142

BIRTH NO. _____		REG. DIST. NO. <u>96</u>		PRIMARY REG. DIST. NO. <u>6290</u>		Registrar's No. <u>732</u>	
1. PLACE OF DEATH a. COUNTY <u>Dallas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Buffalo Mo</u>		c. LENGTH OF STAY (In this place) <u>3 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Route #1</u>		<u>0300</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route # 1 Buffalo, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>Buffalo, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Millie</u>			b. (Middle) _____		c. (Last) <u>Jeffryes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 13, 1950</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 27 1880</u>	
9. AGE (In years last birthday) <u>69</u>		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) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Harrison Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John D. Briggs</u>			13b. MOTHER'S MAIDEN NAME <u>Melisa C. Briggs</u>		14. NAME OF HUSBAND OR WIFE <u>Robert E. Jeffryes</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert E. Jeffryes Rt#1 Buffalo, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal Bronchial Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized metastatic carcinoma</u>					<u>6 mo</u>
		DUE TO (c) <u>Carcinoma colon</u>					<u>2 yr</u>
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>153X</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) _____ m.		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>6-27</u> , 19 <u>50</u> , to <u>6-27</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>6-27</u> , 19 <u>50</u> , and that death occurred at <u>6 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Buffalo Mo.</u>		23c. DATE SIGNED <u>15 July 50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/16/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7/22/50</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>80</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>			

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

DIVISION OF HEALTH OF MD.

District No. 5 - Springfield

RECEIVED JUL 25 1950

Dist. File 750-892

Date Filed 7-31-50

1950

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 Walter E. Hamella.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 3808

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.