

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23315

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 698

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Webster	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Marshfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 1121	

3. NAME OF DECEASED (Type or Print) a. (First) Lenora b. (Middle) Francis c. (Last) Mackey			4. DATE OF DEATH (Month) (Day) (Year) August 3 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 15, 1875	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Marshfield, Mo.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Joe Shook	13b. MOTHER'S MAIDEN NAME Mary Calloway	14. NAME OF HUSBAND OR WIFE Ward B. Mackey
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Thomas J. Mackey, Marshfield, Mo. ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial insufficiency		6 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c)		58 4-X
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Cholecysto-gastric fistulae, Cholelithiasis 1 year	

19a. DATE OF OPERATION 6-16-50	19b. MAJOR FINDINGS OF OPERATION Cholelithiasis, Cholecystitis, Cholecysto gastric fistulae	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 June, 1950, to August 3, 1950, that I last saw the deceased alive on August 3, 1950, and that death occurred at 5 P m., from the causes and on the date stated above.

23a. SIGNATURE R.D. Duncan (Degree or title) MD		23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 8-7-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-6-50	24c. NAME OF CEMETERY OR CREMATORY Marshfield	24d. LOCATION (City, town, or county) (State) Marshfield, Mo.
DATE REC'D BY LOCAL REG. 8-8-50	REGISTRAR'S SIGNATURE H.C. Hawley	25. FUNERAL DIRECTOR'S SIGNATURE Denver Roller, Marshfield, Mo. ADDRESS	

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

1396

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 Denver Rolles.....

Licensed Embalmer No. 4006.....

P. O. Address Marshfield 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.