S. No. 300
v. 10.48

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FILED AUG 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24454

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 4457 Registrar's No. 49

1. PLACE OF DEATH
a. COUNTY St. Clair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lowry City
c. LENGTH OF STAY (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Stone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Reed Springs 1040
d. STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print) a. (First) Clara b. (Middle) C. Bass c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) 7/27/1950

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 4, 1852
9. AGE (In years last birthday) 98 — IF UNDER 1 YEAR Months 6 Days 23 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Springfield Missouri
12. CITIZEN OF WHAT COUNTRY? Usa

13a. FATHER'S NAME James Massey
13b. MOTHER'S MAIDEN NAME Martha Anderson
14. NAME OF HUSBAND OR WIFE Deceased

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. None
17. INFORMANT'S SIGNATURE OR NAME Myrtle Welch Lowry City Mo. ADDRESS

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) Bron Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

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. 491X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 25, 1950, *to* July 27, 1950, *that I last saw the deceased alive on* July 27, 1950, *and that death occurred at* 7:40 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE C. S. Stratton M.D. (Degree or title)
23b. ADDRESS Lowry City Mo
23c. DATE SIGNED 7-28-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-29-50
24c. NAME OF CEMETERY OR CREMATORY Ponce De Leon
24d. LOCATION (City, town, or county) Stone County (State) Mo

DATE REC'D BY LOCAL REG. 7-28-50
REGISTRAR'S SIGNATURE Ruth Sievers 288 0
25. FUNERAL DIRECTOR'S SIGNATURE F B Goodrich ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 8-2-5
DISTRICT HEALTH OFFICE No. 3
District File Number
Date Filed 8-2-50

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 Roy Miller

Licensed Embalmer No. 4492

P. O. Address Osceola, 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.