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FILED SEP 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26586

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 794

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) 1305 N. Benton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Margaret	b. (Middle) Jane	c. (Last) Henry	4. DATE OF DEATH (Month) (Day) (Year) Sept. 5 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 21 Sept. 1864	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY In-Home	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ben Dillbeck	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; or if unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs. Frank Allen	ADDRESS Springfield, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days 142X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, acute, st.		
	ANTECEDENT CAUSES DUE TO (b) Senility DUE TO (c) Cardiovascular renal disease years		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from **Aug 29 1950**, to **Sept 5, 1950**, that I last saw the deceased alive on **Sept 4, 1950** and that death occurred at **6:00a** m., from the causes and on the date stated above.

23a. SIGNATURE Don Silaby (Degree or title)	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 9-6-50
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	24b. DATE 9-7-50	24c. NAME OF CEMETERY OR CREMATORY DAY CEMETERY	24d. LOCATION (City, town, or county) (State) NEAR SEYMOUR Mo.
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DATE REC'D BY LOCAL REG. 9-7-50	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.	ADDRESS Springfield
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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.

Signed.....
Student Embalmer

Signed *Ogle Stone Jr.*.....

Licensed Embalmer No. *4126*.....

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.