

FILED OCT 6 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **29335**

BIRTH NO. _____		REG. DIST. NO. <u>2</u>		PRIMARY REG. DIST. NO. <u>4021</u>		Registrar's No. <u>12</u>	
1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Ladonia</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Vandalia</u>		<u>8141</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Britton's Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>214 West Woodlawn</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Betty</u> b. (Middle) <u>S.</u> c. (Last) <u>Clithero</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sep 27, 1950</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sep 10, 1863</u>	
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>17</u> Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during habit of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Audrain County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>Granville Henderson</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hamlett</u>		14. NAME OF HUSBAND OR WIFE <u>John Clithero</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Joe Clithero, Vandalia, Missouri</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, ashenia, etc. - It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> 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. <u>fracture hip</u>					INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u> <u>6:30 PM</u> <u>2:1</u> <u>2 months</u>
19a. DATE OF OPERATION <u>7/24/50</u>		19b. MAJOR FINDINGS OF OPERATION <u>fracture surgical neck 104</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>back yard</u>		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Vandalia Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 24 1950</u> m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fell coming onto lawn</u>			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1950</u> , to <u>Sept 27, 1950</u> that I last saw the deceased alive on <u>Sept 27, 1950</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Emmaltherene M.D.</u> (Degree or title)			23b. ADDRESS <u>Vandalia Mo.</u>			23c. DATE SIGNED <u>Sept 27, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sep 28, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Central Union Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Vandalia, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>28-50</u>		REGISTRAR'S SIGNATURE <u>Maitte</u>		STATE HEALTH DIRECTOR'S SIGNATURE <u>Waters</u>		ADDRESS <u>Vandalia, Missouri</u>	

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

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4

Date Received: OCT 4 1950
DISTRICT HEALTH OFFICE #2
District File Number 10-50-164
Date Filed: OCT 5 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.

Student
Student Embalmer

Signed Ami B. Grater

Licensed Embalmer No. 4169

P. O. Address Wendalia, 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.