

FILED OCT 16 1950

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

30233

State File No.

 BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u> <u>0460</u>	
c. LENGTH OF STAY (in this place township) <u>3 days</u>		d. STREET ADDRESS (If rural, give location) <u>Route 3</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Stoll Surgical Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Betty</u> b. (Middle) <u>Jean</u> c. (Last) <u>Downen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 13 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 5, 1927</u>
9. AGE (In years last birthday) <u>22</u>	IF UNDER 1 YEAR (Month) (Day) (Year) <u>11 8</u>	IF UNDER 24 HRS. (Hours) (Min.) <u>8</u>	
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>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Gene Coursey</u>		13b. MOTHER'S MAIDEN NAME <u>Laura ?</u>	14. NAME OF HUSBAND OR WIFE <u>Willie Downen</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME 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) <u>NOT KNOWN</u> ANTECEDENT CAUSES <u>Rapidly failing health</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>for two months. Died soon after admission to hospital before</u> DUE TO (c) <u>medical attention could be secured. Reported to coronor.</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>8/11/50</u> , 19 <u>50</u> , to <u>8/13/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>8/15</u> , 19 <u>50</u> , and that death occurred at <u>7:15 pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u> (Degree or title)		23b. ADDRESS <u>West Plains</u>	23c. DATE SIGNED <u>8/21/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	24b. DATE <u>8-16-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>West Plains, Missouri</u>
DATE REC'D BY LOCAL REG. <u>10-5-50</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robertson Funeral Home West Plains, Mo.</u>	

DIVISION OF HEALTH OF MD.
District No. 5 - Springfield

RECEIVED **OCT 9 1950**

Dist. File 1050-2279

Date Filed 10-9-50

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.