

No. 300  
10.48

FILED NOV 14 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34356

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 5932 Registrar's No. 347

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LaMonte Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LaMonte</u>	
c. LENGTH OF STAY (In this place) <u>52yr</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Maude</u> b. (Middle) <u>May</u> c. (Last) <u>Sevier</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11-5-1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 1 1897</u>
9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>4</u>	IF UNDER 1 HR. Hours <u>4</u>	IF UNDER 15 MIN. Min.
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 <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Daniel Tavis</u>	
13b. MOTHER'S MAIDEN NAME <u>Ide May Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Oliver Sevier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Oliver Sevier</u>		ADDRESS <u>LaMonte Mo</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</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>① 2 whl. Old Fracture of left tibia</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Fayetteville, Mo. LaMonte</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Pettis Mo</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct 21 1932 9:30 m.</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Truck miss steps and I twisted ankle</u>	
22. I hereby certify that I attended the deceased from <u>Oct 22, 1932</u> , to <u>Nov 5, 1950</u> that I last saw the deceased alive on <u>Nov 5, 1932</u> , and that death occurred at <u>2:17 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>G. W. Brown M.D.</u> (Degree or title)		23b. ADDRESS <u>Knobnoster Mo.</u>	
23c. DATE SIGNED <u>Nov 7-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>11-7-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LaMonte Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>LaMonte Mo</u>		DATE REC'D BY LOCAL REG. <u>11-9-1950</u>	
REGISTRAR'S SIGNATURE <u>G. Campbell M.D.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Paul M. More de Mont M.D.</u>	
ADDRESS _____		ADDRESS _____	

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

(Licensed Embalmer's Statement on Reverse Side)

**RECEIVED** 11-18-50  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed 11-13-50

APR 17 1951

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**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 Paul M. Moore

Licensed Embalmer No. 3923

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.