

FILED NOV 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34530
Registrar's No. 346

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 4461

1. PLACE OF DEATH a. COUNTY <u>ST FRANCIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST FRANCIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BISMARCK</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BISMARCK</u> <u>0940</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Luviey</u> b. (Middle) <u>Ketcheside</u> c. (Last) <u>Ketcheside</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 20 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>MAR 16, 1892</u>
9. AGE (In years last birthday) <u>58</u> if under 1 year <u>7</u> if under 1 month <u>4</u>		10. a. 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>Reynolds Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>AMOS MEADE</u>	
13b. MOTHER'S MAIDEN NAME <u>CORDELIA ASBERRY</u>		14. NAME OF HUSBAND OR WIFE	
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 <u>Raymond Ketcheside</u>		ADDRESS <u>Bismarck, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chenury B.</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 yr</u>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		<u>DO 2X</u>	

19a. DATE OF OPERATION		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) (Min)		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 July 1, 1950 to Oct 20, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>F. H. Gale M.D.</u> (Degree or title)		23b. ADDRESS <u>Bismarck, Mo.</u>		23c. DATE SIGNED <u>Oct 21 50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Oct 22, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>BISMARCK MASONIC</u>	
24d. LOCATION (City, town, or county) <u>BISMARCK</u>		24e. (State) <u>MO</u>			

DATE REC'D BY LOCAL REG. <u>Oct 22 1950</u>		REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Shipman-Sparks</u>	
				ADDRESS <u>Bismarck, Mo.</u>	

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 30 1950

RECEIVED

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 *Murphy L. ...* _____

Licensed Embalmer No. *4236* _____

P. O. Address *St. ...* _____

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.