

FILED DEC 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36112

070

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

BIRTH NO. _____		REG. DIST. NO. <u>25</u>		PRIMARY REG. DIST. NO. <u>4036</u>		Registrar's No. <u>31</u>	
1. PLACE OF DEATH a. COUNTY <u>BATES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>BATES</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RICH HILL</u>		c. LENGTH OF STAY (In this place) <u>3 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RICH HILL</u>		<u>0070</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>201 E. PARK AVE.</u>				d. STREET ADDRESS (If rural, give location) <u>201 E. PARK AVE.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MICHAEL</u> b. (Middle) <u>JOHN</u> c. (Last) <u>LOUNSBURY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DEC-8-1950</u>				
5. SEX <u>U</u>		6. COLOR OR RACE <u>MALE WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>NOV. 5, 1856</u>	
9. AGE (In years last birthday) <u>94</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>WILLIAM LOUNSBURY</u>		13b. MOTHER'S MAIDEN NAME <u>ELLEN HOPPER</u>		14. NAME OF HUSBAND OR WIFE <u>SARAH LOUNSBURY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NAME</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Edna Campbell-Ruth Healy</u> 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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio Sclerosis</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) _____				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>442-X</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 <u>Nov 15, 1950</u> , to <u>Nov 1950</u> , that I last saw the deceased alive on <u>Dec 8, 1950</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Charles J. Allen</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Rich Hill Mo</u>		23c. DATE SIGNED <u>Nov 9 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>DEC-10-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>UNDERWOOD CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>BATES COUNTY-MO</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 10, 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. Edna Douglas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Broth Funeral Soc - Rich Hill Mo</u> ADDRESS _____			

RECEIVED 12-12-50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 12-12-50 _____

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed *John G. Underwood*
Licensed Embalmer No. *3585*

P. O. Address *Butler MD*

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.