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FILED DEC 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Musick
State File No. 36783

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 1067

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Rural N. Campbell Twp		c. CITY (If outside corporate limits, write RURAL and give township) Rural N. Campbell Township	
c. LENGTH OF STAY (In this place) 3 Mo.		d. STREET ADDRESS (If rural, give location) W. Highway # 66 R#4	
d. FULL NAME OF HOSPITAL OR INSTITUTION Warnick Rest Home R#4			

3. NAME OF DECEASED (Type or Print)	a. (First) Nellie	b. (Middle) Stone	c. (Last) Wilson	4. DATE OF DEATH (Month) (Day) (Year) Dec 2, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH April 8 1872	9. AGE (In years) (Month) (Day) (Year) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HOURS Hours	IF UNDER 2 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) Marysville, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Pete Stout	13b. MOTHER'S MAIDEN NAME Sarah Scott	14. NAME OF HUSBAND OR WIFE X
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Personal Papers	ADDRESS
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18. CAUSE OF DEATH Enter 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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, cerebral		12, 1, 50
	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.		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **12, 1, 1950**, to **12, 2, 1950**, that I last saw the deceased alive on **12, 1, 1950**, and that death occurred at **3:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. H. Handley M.D.	23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 12, 4, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-5-50	24c. NAME OF CEMETERY OR CREMATORY HAZELWOOD	24d. LOCATION (City, town, or county) (State) Spfld. Mo.
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DATE REC'D BY LOCAL REG. 12-5-50	REGISTRAR'S SIGNATURE W. H. Handley M.D.	25. FUNERAL DIRECTOR'S SIGNATURE H. H. Lohmeyer	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 W. L. Mc Corm

Licensed Embalmer No. 2727

P. O. Address Springfield 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.