

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37567

BIRTH NO. _____ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 423E Registrar's No. 611

1. PLACE OF DEATH a. COUNTY Knox		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Knox	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Edina		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Baring	
d. FULL NAME OF HOSPITAL OR INSTITUTION The Gibson Hospital.		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Lydia	b. (Middle) May	c. (Last) Slocum	(Month) Nov-24	(Day)	(Year) 1950
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug-28-1892	9. AGE (In years last birthday) 6.7	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Greensburg, Missouri.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Francis S. Fetters	13b. MOTHER'S MAIDEN NAME Lillian B. Asbury	14. NAME OF HUSBAND OR WIFE William Slocum
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. none	17. INFORMANT'S SIGNATURE OR NAME William Slocum ADDRESS Baring, Missouri.

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		INTERVAL BETWEEN ONSET AND DEATH 3 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General Carcinomatosis		
	ANTECEDENT CAUSES DUE TO (b) Carcinoma Sigmoid Colon DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		153X	
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) m.	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 10-25, 1950, to 11-24, 1950, that I last saw the deceased alive on 11-24, 1950, and that death occurred at 3:12 P. m., from the causes and on the date stated above.

23a. SIGNATURE Raymond S. Mabrey, M.D.	(Degree or title) 2	23b. ADDRESS Edina, Mo	23c. DATE SIGNED 11-25-50
24a. BURIAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov-26-1950	24c. NAME OF CEMETERY OR CREMATORY Greensburg.	24d. LOCATION (City, town, or county) (State) Greensburg, Missouri.

DATE REC'D BY LOCAL REG. Nov. 27-1950	REGISTRAR'S SIGNATURE Nell S. Humalt	151	25. FUNERAL DIRECTOR'S SIGNATURE Ruth Hudson	ADDRESS Edina Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Received: DEC 4 1958
DISTRICT HEALTH OFFICE #2
District File Number 12-58-20
Date Filed: DEC 7 1958

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

North Hudson

Licensed Embalmer No. *2415*

P. O. Address *Edina Mission*

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: