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FILED DEC 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38085

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 394

1. PLACE OF DEATH
a. COUNTY: Randolph
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Randolph
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
d. STREET ADDRESS (If rural, give location): 626 McKinley

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3. NAME OF DECEASED (Type or Print)
a. (First) RUTH b. (Middle) ROBERTA c. (Last) GEE

4. DATE OF DEATH (Month) (Day) (Year): Nov-26-1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct-24-1893
9. AGE (In years last birthday): 57 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Earlville Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Lee Lambert
13b. MOTHER'S MAIDEN NAME: Mae Cavan
14. NAME OF HUSBAND OR WIFE: James Gee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: James Gee — ADDRESS: Moberly 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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ???

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.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 25th 1950, *to* Nov 26th 1950, *that I last saw the deceased alive on* Nov 25th 1950, *and that death occurred at* 545 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thos. S. Fleming M.D.
23b. ADDRESS: Moberly, Missouri
23c. DATE SIGNED: Nve 26

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov-29-1950
24c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
24d. LOCATION (City, town, or county) (State): Moberly Missouri

DATE REC'D BY LOCAL REG.: Nov 29.50
REGISTRAR'S SIGNATURE: Leah Williams Lowe 269
25. FUNERAL DIRECTOR'S SIGNATURE: Snow Funeral Home — ADDRESS: Moberly Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed R. M. Cater

Signed.....
Student Embalmer

Licensed Embalmer No. 4117

P. O. Address Moberly 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.