

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1951

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **5003** Registrar's No. **29**

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give town) Rural--Morrow Twp.		c. CITY (If outside corporate limits, write RURAL and give township) Rural--Morrow Twp.	
c. LENGTH OF STAY (In this place) 19 yrs.		d. STREET ADDRESS (If rural, give location) RFD #3, Novinger, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home--2 mi. NE Stahl			

3. NAME OF DECEASED a. (First) Sarah b. (Middle) Amanda c. (Last) Rouse			4. DATE OF DEATH (Month) Jan. (Day) 14 (Year) 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 8, 1930	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Farm home	11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George White	13b. MOTHER'S MAIDEN NAME Sarah Scobee	14. NAME OF HUSBAND OR WIFE Pearl Rouse
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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. None	17. INFORMANT'S SIGNATURE OR NAME Pearl Rouse	ADDRESS RFD #3, Novinger, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Liver		INTERVAL BETWEEN ONSET AND DEATH but after 156A
	ANTECEDENT CAUSES Morbidity 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.		

19a. DATE OF OPERATION None	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)	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 Jan 10, 1950, to Jan 14, 1951, that I last saw the deceased alive on Jan 13, 1951, and that death occurred at _____ m. from the causes and on the date stated above.

23a. SIGNATURE L. P. Harrison M.D.	23b. ADDRESS Novinger Mo	23c. DATE SIGNED Jan 4-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 17, 1951	24c. NAME OF CEMETERY OR CREMATORY Morelock Cemetery	24d. LOCATION (City, town, or county) (State) Adair County, Mo.
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DATE REC'D BY LOCAL REG. 1-16-51	REGISTRAR'S SIGNATURE Walter Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Glenn E. Kent & Son	ADDRESS Green City Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten scribbles and illegible text at the top left of the page.

Date Received: JAN 22 1951
DISTRICT HEALTH OFFICE #2
District File Number /-5/-22
Date Filed: FEB 5 1951

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. *22311*

working under my personal supervision.

Student
Student Embalmer

Signed *Karl R. Kent*

Licensed Embalmer No. *4689*

P. O. Address *Green City, 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.