

FILED JAN 23 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1669

BIRTH NO. 124 REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lexington</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Higginsville</u> <u>0541</u>	
c. LENGTH OF STAY (In this place) <u>10 Days</u>		d. STREET ADDRESS (If rural, give location) <u>West main</u> <u>0</u>	
d. FULL NAME OF (If in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jessie</u> b. (Middle) <u>Thelma</u> c. (Last) <u>McCord</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 1 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 12, 1900</u>	9. AGE (In years last birthday) <u>50</u>	<u>4</u> Months <u>9</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Carthage, Mo</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Joseph Sparks</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie West</u>	14. NAME OF HUSBAND OR WIFE <u>Forrest Lee McCord</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Forrest Lee McCord Higginsville, Mo</u>

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic carcinoma of brain</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last.</u>		DUE TO (b) <u>Carcinoma of ovary with generalized metastasis:</u>		<u>unknown</u>
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		<u>175x</u>

19a. DATE OF OPERATION <u>7-10-50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the right ovary with metastasis,</u>	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 1-1-51, 1951, and that death occurred at 10:15A on 1-1-51, 1951, that I last saw the deceased alive on 1-1-51, 1951, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert A. Bone, No. 10</u>	23b. ADDRESS <u>Higginsville, Missouri</u>	23c. DATE SIGNED <u>1-9-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-4-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>Higginsville, Mo.</u>

DATE REC'D BY LOCAL REG. <u>Jan 18, 1951</u>	REGISTRAR'S SIGNATURE <u>Marion E. Embalmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Higginsville, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

542  
0

RECEIVED 122-5/  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed 122-5/

STATEMENT BY LICENSED EMBALMER

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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.

Signed Forrest A. Hooper

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4558

P. O. Address Higginsville, 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.