

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 23 1951

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 4470 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>Saline</u> <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Arrow Rock, Mo.</u>)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: <u>ARROW ROCK</u> <u>0000</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Arrow Rock, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>Arrow Rock, Mo.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Sophie</u>	b. (Middle) <u>Bell</u>	c. (Last) <u>Parker</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>1/14/51</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 14, 1884</u>	9. AGE (In years last birthday) <u>66</u>	10 UNDER 1 YEAR <u>10</u> MONTHS <u>10</u> DAYS	11 UNDER 1 HR. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	11. BIRTHPLACE (State or foreign country) <u>Arrow Rock, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Falls</u>	13b. MOTHER'S MAIDEN NAME <u>Marchia Falls</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Guy Parker</u>	ADDRESS <u>Arrow Rock, Mo.</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		<u>48 hrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hemiplegia</u>		<u>15 Days.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>334X</u>

19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <input checked="" type="checkbox"/>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <input checked="" type="checkbox"/> m. <input type="checkbox"/> a.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>
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22. I hereby certify that I attended the deceased from Jan 2nd, 1951, to Jan 14, 1951, that I last saw the deceased alive on Jan 13, 1951, and that death occurred at 2:40 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Waite H. Madison, M.D.</u>	(Degree or title)	23b. ADDRESS <u>Marshall, Mo.</u>	23c. DATE SIGNED <u>1-16-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1/17/1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sappington Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Saline County, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Jan-17-1951</u>	REGISTRAR'S SIGNATURE <u>Sidney F. Gray</u>	FUNERAL DIRECTOR'S SIGNATURE <u>George H. Green</u>	ADDRESS <u>Marshall, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed _____

JAN 30 1951

RECEIVED 1-22-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 1-22-51

JAN 23 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 _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed _____
Student Embalmer No. _____

Licensed Embalmer No. 4220

P. O. Address Marshall, 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.