

FILED JUL 30 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21967

BIRTH NO. _____		REG. DIST. NO. <u>11</u>		PRIMARY REG. DIST. NO. <u>4025</u>		Registrar's No. <u>49</u>	
1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Wheaton</u>		c. LENGTH OF STAY (In this place) <u>10 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		<u>0730</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Wheaton Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Stark City, Mo. R#</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Helen</u> b. (Middle) <u>Jane</u> c. (Last) <u>Buxton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 11 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>Jan. 5 1910</u>		9. AGE (In years last birthday) <u>41</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 24 HRS. Days <u>5</u> Hours _____ Min. _____
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>same</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Arch Wolgamott</u>			13b. MOTHER'S MAIDEN NAME <u>Celia Josephine Kincaid</u>		14. NAME OF HUSBAND OR WIFE <u>Harlin Buxton</u>		
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 ADDRESS <u>Harlin Buxton Stark City, Mo. R#</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					<u>4 years</u>	
	DUE TO (c) <u>Hepatitis</u>					<u>4 years</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Eclampsia (x pregnancy)</u>					<u>4 years</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331x8</u>						
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)		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 <u>May</u> , 19 <u>50</u> , to <u>July</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>51</u> , and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Fred R. Clark D.O.</u>			23b. ADDRESS <u>Wheaton Hospital</u>		23c. DATE SIGNED <u>7/12/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7/15/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Dice Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Fairview, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>July 19-1951</u>	REGISTRAR'S SIGNATURE <u>Grace Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm Morris Pope Wheaton Mo.</u>				

(Licensed Embelmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED

JUL 23 1924

Dist. File 2517393
Date Filed 7-26-24

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 Wm Morris Pogue

Licensed Embalmer No. 3442

P. O. Address Wheaton, 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.