

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Turner
State File No. 29951

FILED OCT 8 1951

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 829

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Mt. View	
c. LENGTH OF STAY (in this place) 9 Days		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) Ellen	b. (Middle) Becker	c. (Last) Becker	4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH January 29, 1884	9. AGE (in years last birthday) 67	IF UNDER 1 YEAR 0 Months 0 Days	IF UNDER 24 HRS. 0 Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Dave Gusong	13b. MOTHER'S MAIDEN NAME Meg Payne	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Ida Abbey, Mt. View, Missouri	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) A. ARTERIOSCLEROTIC HEART DS. WITH ATRICULAR FIBRILLATION AND CONGESTIVE FAILURE.		
	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.			

19a. DATE OF OPERATION	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) (Minute)	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 **11/22/49, 19**, to **9/27/51, 19**, that I last saw the deceased alive on **9/27/51, 19**, and that death occurred at **4:30pm.**, from the causes and on the date stated above.

22a. SIGNATURE Glenn T. Turner, M.D.	(Degree or title)	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 9/29/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/30/51	24c. NAME OF CEMETERY OR CREMATORY Mt View	24d. LOCATION (City, town, or county) (State) Mt View, MO
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DATE REC'D BY LOCAL REG. 10-1-51	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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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 Lucian T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield

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.