

FILED SEP 24 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29991

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 800

# 396

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

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield, Rural, S. Campbell</b>	
c. LENGTH OF STAY (In this place) <b>4 Da.</b>		d. STREET ADDRESS (If rural, give location) <b>2408 S. Holland</b> Twp	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>UZARK OSTEOPATHIC HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Anna</b>	b. (Middle)	c. (Last) <b>Lytle</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 16, 1951</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 8, 1890</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>IN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>Gallsburg Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
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13a. FATHER'S NAME <b>Bill Maloney</b>	13b. MOTHER'S MAIDEN NAME <b>Amanda Smith</b>	14. NAME OF HUSBAND OR WIFE <b>Frank H. Lytle</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Frank Lytle</b>	ADDRESS <b>Springfield MO</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Metastatic Carcinoma of Uterus, Vaginal tract, intestines, and liver.</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b)</b>		
	<b>DUE TO (c)</b>		
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) <b>176X</b>
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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 9/12/51, 1951, to 9/16/51, that I last saw the deceased alive on 9/15, 1951, and that death occurred at 1:35 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>William D. Welch, D.O.</b>	23b. ADDRESS <b>700 E. Sunshine</b>	23c. DATE SIGNED <b>9/17/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept 19, 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield Mo.</b>
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DATE REC'D BY LOCAL REG. <b>9-19-51</b>	REGISTRAR'S SIGNATURE <b>W. E. Handley</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Klingner &amp; Co. Spgs.</b>	ADDRESS <b>2711 B.</b>
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(Licensed Embalmer's Signature on Reverse Side)

JUL 11 1968

A STATE OF DELAWARE CERTIFICATE

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 *Max Rhodes*

Licensed Embalmer No. *4071*

P. O. Address *Spring Hill*

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.