

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 999

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Burge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY Dallas
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Buffalo, Rural 0305
d. STREET ADDRESS (If rural, give location) Elkland Route 1

3. NAME OF DECEASED
a. (First) Mollie b. (Middle) Ray c. (Last) Breshears

4. DATE OF DEATH (Month) (Day) (Year)
Nov. 21, 1951

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 12, 1921

9. AGE (In years last birthday) 79

IF UNDER 1 YEAR Hours Days
IF UNDER 24 HRS. Min.

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) Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Thomas Ray

13b. MOTHER'S MAIDEN NAME Sarah Maberly

14. NAME OF HUSBAND OR WIFE J. N. Breshears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. N. Breshears Buffalo, Mo

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stone in Gall bladder
MEDICAL CERTIFICATION
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gall bladder disease
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Jecunosis and hepatitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Jecunosis, hepatitis, Common bile duct stone

20. AUTOPSY? YES NO

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) Mo

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 584X

22. I hereby certify that I attended the deceased from Nov 21, 1951, to Nov 21, 1951, that I last saw the deceased alive on Nov 21, 1951, and that death occurred at 1:30pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. H. ...

23b. ADDRESS Springfield, Mo

23c. DATE SIGNED 11-21-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried

24b. DATE 11-21-51

24c. NAME OF CEMETERY OR CREMATORY W. Oak Lawn

24d. LOCATION (City, town, or county) (State) Buffalo, Missouri

DATE REC'D BY LOCAL REG. 11-21-51

REGISTRAR'S SIGNATURE W. H. ...

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L. B. Jones Buffalo, Mo

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

396
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Leonard B. Jones*.....

Licensed Embalmer No. *2508*.....

P. O. Address *Buffalo 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.