

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37840
Registrar's No. 125

64920

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

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3129

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY McDONALD	
b. CITY (If outside corporate limits, write RURAL and give township) WEBB-CITY-		c. CITY (If outside corporate limits, write RURAL and give township) LANAGAN	
c. LENGTH OF STAY (in this place) 8 DAS		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION JANE-CHINN Hosp			
3. NAME OF DECEASED a. (First) MYRTLE		b. (Middle) INA	
c. (Last) HALE		4. DATE OF DEATH (Month) (Day) (Year) 10-25-51	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6-3-1876
9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	11. BIRTHPLACE (State or foreign country) ADAIR-CO. KY.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME SAMUEL J. SMITH		13b. MOTHER'S MAIDEN NAME ELIZABETH BEARD	
14. NAME OF HUSBAND OR WIFE BERT HALE		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. NONE		17. INFORMANT'S SIGNATURE OR NAME Mrs. Chas. Taylor Joseph	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 Day ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congenital Hemorrhage 2 weeks	
19a. DATE OF OPERATION 10-21-51	19b. MAJOR FINDINGS OF OPERATION Recovery from Pneumonia		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 Oct 1, 1951 , to Oct 23, 1951 , that I last saw the deceased alive on Oct 22, 1951 , and that death occurred at 6 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE J. Dawson		23b. ADDRESS Webb City, Mo.	23c. DATE SIGNED 10/25/51
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10-25-51	24c. NAME OF CEMETERY OR CREMATORY PINEVILLE	24d. LOCATION (City, town, or county) (State) PINEVILLE-MO.
DATE REC'D BY LOCAL REG. Dec 4-51	REGISTRAR'S SIGNATURE J. L. Dute	25. FEDERAL DIRECTOR'S SIGNATURE K. M. Humphrey	

Jasper County Health Office

County File Number.....

Date Filed.....

RECEIVED 12-6-51
Jasper County Health Office
County File Number 51/12/919
Date Filed ~~12-6-51~~ 12-6-51

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 *J. M. Humphrey Jr.*.....

Licensed Embalmer No. 4708.....

P. O. Address *Noel, 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.