

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4615

State File No.

FILED MAR 10 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 225

396
1

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

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MARSHFIELD MO 1120</u>	
c. LENGTH OF STAY (In this place) <u>7 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1627 CAIRD</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>HARRIET</u> b. (Middle) <u>OPHELIA</u> c. (Last) <u>GEER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAR 4 1952</u>		
---	--	--	---	--	--

5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>SEPT 26 1881</u>		9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
----------------------	--	-------------------------------	--	---	--	--------------------------------------	--	---	--	---	--	---	--

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>HOUSE</u>			11. BIRTHPLACE (State or foreign country) <u>MARSHFIELD MO</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
--	--	--	--	--	--	--	--	--	---	--	--

13a. FATHER'S NAME <u>FRANKLIN MINOR</u>			13b. MOTHER'S MAIDEN NAME <u>HARRIET McNABB</u>			14. NAME OF HUSBAND OR WIFE <u>SAMUEL GEER</u>		
--	--	--	---	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. A.T. McQuay Springfield MO</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>Coronary Occlusion, acute</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, genl.</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychitis, acute</u>						INTERVAL BETWEEN ONSET AND DEATH <u>less than 1 hr</u> <u>at least 2 yrs.</u> <u>about 2 wks.</u>	
---	--	--	--	--	--	--	--	--	--

19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				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) <u>4201</u>	
--	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			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 Jan 1, 1950, to Mar 3, 1952, that I last saw the deceased alive on Mar 3, 1952, and that death occurred at home, from the causes and on the date stated above.

23a. SIGNATURE <u>James E. Krueger MD</u>		23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>5 Mar 52</u>	
---	--	--------------------------------------	--	----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3-7-1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>TIMBER RIDGE</u>		24d. LOCATION (City, town, or county) (State) <u>WEBSTER CO MO</u>	
---	--	---------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. <u>3-7-52</u>		REGISTRAR'S SIGNATURE <u>James R. C... MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BARBER-BARTO MARSHFIELD, MO</u>	
--	--	---	--	---	--

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 Rw Barber

Licensed Embalmer No. 3848

P. O. Address Marshfield 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.