

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8062

State File No. ....

FILED MAR 17 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 240

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u> | c. LENGTH OF STAY (in this place) <u>2mo. 26days</u> | c. CITY (If outside corporate limits, write RURAL and give township) <u>Bolivar</u> <u>0841</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>                       |  | d. STREET ADDRESS (If rural, give location) <u>/</u>   |  |

|   |            |             |                            |   |
|---|------------|-------------|----------------------------|---|
| 3. NAME OF DECEASED (Type or Print) <u>Mollie</u> | a. (First) | b. (Middle) | c. (Last) <u>Scrivener</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>March 8 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>Dec. 9, 1874</u> | 9. AGE (In years last birthday) <u>77</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 HRS. Hours | IF UNDER 15 MIN. Min. |
|----------------------|-------------------------------|---|--------------------------------------|---|------------------------|-----------------------|-----------------------|-----------------------|

|  |   |   |  |
|--|---|---|--|
| 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>HOME</u> | 11. BIRTHPLACE (State or foreign country) <u>Sherman, Texas</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|---|---|--|

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|---|--|--|
| 13a. FATHER'S NAME <u>James L. Mitchell</u> | 13b. MOTHER'S MAIDEN NAME <u>Bettie Alice Hord</u> | 14. NAME OF HUSBAND OR WIFE <u>---</u> |
|---|--|--|

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. J.P. McDaniel</u> | ADDRESS <u>1340 S. Birminham, Tulsa, Ok.</u> |
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|--|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><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 <u>UNKNOWN</u> |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MALIGNANCY, PRIMARY SITE UNDETERMINED, WITH PLEURAL AND PERITONEAL METASTASES</u>                      |  |   |
|  | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |   |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>1998</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) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 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 12/12/51, 19 to 3/8/52, 19, that I last saw the deceased alive on 3/8/52, 19, and that death occurred at 12:25p m., from the causes and on the date stated above.

|   |                   |                                      |                                 |
|---|-------------------|--------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>Glenn O. Turner, M.D.</u> | (Degree or title) | 23b. ADDRESS <u>Springfield, Mo.</u> | 23c. DATE SIGNED <u>3/10/52</u> |
|---|-------------------|--------------------------------------|---------------------------------|

|   |                                |  |   |
|---|--------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 24b. DATE <u>Mar. 10, 1952</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Bolivar, Mo.</u> |
|---|--------------------------------|--|---|

|   |  |   |                             |
|---|--|---|-----------------------------|
| DATE REC'D BY LOCAL REG. <u>3-11-52</u> | REGISTRAR'S SIGNATURE <u>James R. Amos, M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Turpin Funeral Home</u> | ADDRESS <u>Bolivar, Mo.</u> |
|---|--|---|-----------------------------|

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

396  
0

MAY 6 1952

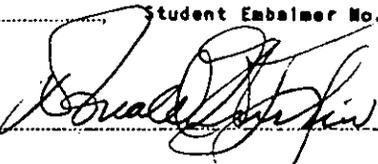
MAY 1 5 1952

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  \_\_\_\_\_  
Licensed Embalmer No. 3053

P. O. Address TBolivar, 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.