No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 5- 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12638

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 423

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 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): 2727 W. Webster

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Greene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield 0396
d. STREET ADDRESS (If rural, give location): 2727 W. Webster

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): A.
c. (Last): LEE

4. DATE OF DEATH (Month) (Day) (Year): April 28, 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 9, 1888
9. AGE (In years last birthday): 63 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: In Home
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John Sparks
13b. MOTHER'S MAIDEN NAME: Mary Zimmerman
14. NAME OF HUSBAND OR WIFE: Widowed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Mrs. Annie Robb Springfield, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardio-Renal Vascular Dis. — INTERVAL BETWEEN ONSET AND DEATH: 10-12 Mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

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: 442X
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-2, 1952, *to* 4-28, 1952, *that I last saw the deceased alive on* 4-28, 1952, *and that death occurred at* 8:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Springfield Mo
23c. DATE SIGNED: 5-2-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5-1-52
24c. NAME OF CEMETERY OR CREMATORY: Danforth Cemetery
24d. LOCATION (City, town, or county) (State): Greene Co. Missouri

DATE REC'D BY LOCAL REG.: 5-3-52
REGISTRAR'S SIGNATURE: James R. Rees, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. W. Klingner & Co. Springfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Ogle Slone Jr.

Signed _____
Student Embalmer

Licensed Embalmer No. 4176

P. O. Address Springfield

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.