

S. No. 300
v. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. TURNER 27718
State File No.

FILED SEP 2- 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 733-A

0396
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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>MISSOURI</u> b. COUNTY <u>HOWELL</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>WEST PLAINS, MO</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>1218 W. MAIN</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN HOSP.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>ONEITA</u> b. (Middle) <u>D.</u> c. (Last) <u>CRIST</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 2, 1952</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>11-9-1900</u>		9. AGE (In years last birthday) <u>51</u>		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Mins.) <u>8 2 22</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>HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>LENEXA, KANSAS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>J. H. PHILIPS</u>		13b. MOTHER'S MAIDEN NAME <u>AMANDA E. MILLER</u>	
14. NAME OF HUSBAND OR WIFE <u>E.R. CRIST</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>E.R. CRIST</u>		ADDRESS <u>WEST PLAINS, MO.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>BRAIN TUMOR METASTATIC FROM CARCINOMA OF CERVIX OF UTERUS</u>			<u>2 WEEKS</u>
		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		<u>Essential hypertension</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>171X</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 7/20/52 to 8/2/52, 1952, that I last saw the deceased alive on 8/1/52, 1952, and that death occurred at 12:25a, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Glenn O. T. ... M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>8/4/52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-2-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	
24d. LOCATION (City, town, or county) (State) <u>WEST PLAINS, MO</u>		24e. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. LOHMEYER</u>		ADDRESS <u>SPRINGFIELD, MO.</u>	

DATE REC'D BY LOCAL REG. <u>8/25/52</u>		REGISTRAR'S SIGNATURE <u>Edith Wellman Registrar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. LOHMEYER</u> ADDRESS <u>SPRINGFIELD, MO.</u>	
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Lucian T. Swadlow*

Licensed Embalmer No. *4815*

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.