

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **42005**

FILED DEC 29 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1132-A**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD 0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE		d. STREET ADDRESS (If rural, give location) 1324 N ROBBERSON	

3. NAME OF DECEASED (Type or Print) a. (First) MINNIE	b. (Middle) MAY	c. (Last) DAVIS	4. DATE OF DEATH (Month) (Day) (Year) DEC. 17 1952
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 26 1875	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOMEMAKING	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME WINFRIED MUSGAVER	13b. MOTHER'S MAIDEN NAME AGNES STEVENS	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. HAZEL MOSER 1312 N. Robberson
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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		INTERVAL BETWEEN ONSET AND DEATH 2 wks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease 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	20. AUTOPSY? 4200 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 1948**, to **12-17-1952**, that I last saw the deceased alive on **12-17-52**, 19**52**, and that death occurred at **6:37 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul C. Morton MD	23b. ADDRESS 1630 N. Jefferson	23c. DATE SIGNED 12-20-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-19-52	24c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	24d. LOCATION (City, town, or county) (State) Springfield Mo.
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DATE REC'D BY LOCAL REG. 12-22-52	REGISTRAR'S SIGNATURE Paul C. Morton	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. KLINGNER & CO SPRINGFIELD MO
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 1132-A

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 _____
Max Rhodes

Licensed Embalmer No. _____
4071

P. O. Address _____
Spring Hill

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.