

FILED JAN 12 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2394**

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. **250** PRIMARY REG. DIST. NO. **5878** Registrar's No. **1**

750
1

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

1. PLACE OF DEATH a. COUNTY OREGON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY OREGON	
b. CITY (If outside of rural district write RURAL and give township) OR TOWN Alton (Woodside)		c. LENGTH OF STAY (in this place)	
c. CITY (If outside of rural district write RURAL and give township) OR TOWN Alton (Woodside 0750)		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) LIZZIE MARGARET TOWNSEND			4. DATE OF DEATH (Month) (Day) (Year) 1 6 53		
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 5-21-1903	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR: Months 7 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Oregon Co MO.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME BOB BRILES	13b. MOTHER'S MAIDEN NAME MODANA ROSS	14. NAME OF HUSBAND OR WIFE ABBOTT TOWNSEND
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Dr. Carhart ADDRESS Alton, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Occlusion		DUE TO (b) Fatty Degeneration		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None		4201

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	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) Alton Oregon MO.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:20**, from the causes and on the date stated above.

23a. SIGNATURE William C. Johnson (Degree or title) D.O.	23b. ADDRESS Alton Mo.	23c. DATE SIGNED 1-9-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-8-1953	24c. NAME OF CEMETERY OR CREMATORY BAILEY CHAPEL CEMETERY
24d. LOCATION (City, town, or county) (State) ALTON MO.	25. FUNERAL DIRECTOR'S SIGNATURE John S. Clay ADDRESS Alton, Mo.	
DATE REC'D BY LOCAL REG. Jan 10-53	REGISTRAR'S SIGNATURE Mrs W. Johnson 233	

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John D. Clary

Licensed Embalmer No. 4475

P. O. Address Box 398, Altus, 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.