

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9477

State File No. ....

FILED APR 14 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 349

396

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>SPRINGFIELD</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>SPRINGFIELD</b> <i>1396</i>	
c. LENGTH OF STAY (in this place) <b>1 YEAR</b>		d. STREET ADDRESS (If rural, give location) <b>1221 W. HARRISON</b> <i>0</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1221 W. HARRISON</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>BEULAH</b>	b. (Middle) <b>E.</b>	c. (Last) <b>ROUSE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 3, 1953</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>DIVORCED</b> <i>3</i>	8. DATE OF BIRTH <b>SEPT. 29 1887</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days	IF UNDER 48 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>CHAMBERSBURG, OHIO</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>JOSHUA TODD</b>	13b. MOTHER'S MAIDEN NAME <b>AMANDA WOOD</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MRS. W.H. TWYFORD, SPFLD, MO.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>none</b> <i>331x</i>		
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? 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) <b>Springfield, Greene, Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Mar 19, 1953**, to **Apr 3, 1953**, that I last saw the deceased alive on **Mar 14, 1953**, and that death occurred at **11:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Dr. W. C. ...</i>	23b. ADDRESS <b>609 Cherry St.</b>	23c. DATE SIGNED <b>Apr 4, 53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>4/5/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GALLIPOLIS CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>GALLIPOLIS, OHIO</b>
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DATE REC'D BY LOCAL REG. <b>4-6-53</b>	REGISTRAR'S SIGNATURE <i>Eartha Williamson</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H.H. LOHMEYER SPRINGFIELD, MO.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

MAY 28 1953

**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 W. L. Mc Conn

Licensed Embalmer No. 2727

P. O. Address Springfield 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.