

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **9516**
 Registrar's No. **320**

FILED MAR 30 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5463**

1390
 1

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

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 townshp) OR TOWN RURAL 2nd JACISON		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give townshp) OR TOWN RURAL 2nd JACKSON		d. STREET ADDRESS (If rural, give location) Strafford RFD#2 0390
d. FULL NAME OF HOSPITAL OR INSTITUTION STRAFFORD RT.# 2					
3. NAME OF DECEASED (Type or Print) a. (First) SOPHRONIA b. (Middle) J. c. (Last) COMSTOCK			4. DATE OF DEATH (Month) (Day) (Year) March 27 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11 April 1862	9. AGE (In years last birthday) 90	# UNDER 1 YEAR Months Days
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 Simpson		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased	
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. No	17. INFORMANT'S SIGNATURE OR NAME Claude Comstock ADDRESS 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-renal-Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH
	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			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) 442x			
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 3-6 , 19 53 , to 3-27 , 19 53 that I last saw the deceased alive on 3-6 , 19 53 , and that death occurred at 1:30A m., from the causes and on the date stated above.					
23a. SIGNATURE Max [Signature]			23b. ADDRESS M.O. Springfield Mo		23c. DATE SIGNED 3-27-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-29-53	24c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery	24d. LOCATION (City, town, or county) (State) Greene County Mo		
DATE REC'D BY LOCAL REG. 3-28-53	REGISTRAR'S SIGNATURE Walter Williamson Registrar		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. KLINGNER & CO. Springfield, Mo.		

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 Ogle Stone Jr

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.