

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Jack Hovell State File No. **13877**

FILED **MAY 11 1953**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **438**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Newton	
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 Diamond	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Infirmary			

3. NAME OF DECEASED (Type or Print) a. (First) Jasper b. (Middle) Edward c. (Last) McBrayer			4. DATE OF DEATH (Month) (Day) (Year) May 1, 1953			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 12, 1868	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Jamesport, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John McBrayer	13b. MOTHER'S MAIDEN NAME Ellen Lumpkin	14. NAME OF HUSBAND OR WIFE Mrs. Jennie A. McBrayer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Jennie A. McBrayer Diamond,
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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		Mo. INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer, skin of upper lip with metastases to cervical lymph nodes.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Drainage		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION No 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) _____
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? 5/1

22. I hereby certify that I attended the deceased from **9/30, 1952** to **5/1, 1953**, that I last saw the deceased alive on **4/29, 1953**, and that death occurred at **12:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Dean Schubert (Degree or title) _____	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 5/1/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 3, 1953	24c. NAME OF CEMETERY OR CREMATORY Woodmen	24d. LOCATION (City, town, or county) (State) Diamond, Missouri
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DATE REC'D BY LOCAL REG. 5-5-53	REGISTRAR'S SIGNATURE Edith Williams	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gorman-Scharf Funeral Home, Inc. Springfield, Missouri
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(Licensed Embalmer's Statement on Reverse Side)

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

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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

Lewis G. Scharff

Licensed Embalmer No. 3802

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.