

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21439

State File No.

FILED JUN 29 1953

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5553 Registrar's No. 37

0460

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

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>South Fork Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>South Fork - Mo.</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>0460 m</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Flora Elvora</u>	b. (Middle)	c. (Last) <u>Jorris</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6-18-53</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>2-23-1872</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>25</u>	IF UNDER 4 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Howell Co - Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Ben H Parker</u>	13b. MOTHER'S MAIDEN NAME <u>Upton</u>	14. NAME OF HUSBAND OR WIFE <u>OB Jorris</u>
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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)	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clara Jorris, Tulsa Okla</u>	ADDRESS <u></u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	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)
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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 type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 15, 1850, to 6-18, 1953, that I last saw the deceased alive on June 4, 1953 and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Richard D. Smith, D.O. West Plains, Mo.</u>	23b. ADDRESS <u>West Plains, Mo.</u>	23c. DATE SIGNED <u>6-23-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>6-20-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wtn. Zion</u>	24d. LOCATION (City, town, or county) (State) <u>South Fork, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6-25-53</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robertson, West Plains, Mo.</u>	ADDRESS <u></u>
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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.....

J. W. Robertson

Licensed Embalmer No. *3482*

P. O. Address *West Plains, 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.