

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38828

State File No.

FILED DEC 14 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5463 Registrar's No. 1100

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 township) OR TOWN Fair Grove Mo.		c. CITY OR TOWN Fair Grove	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION			
e. STREET ADDRESS (If rural, give location) 0390			

3. NAME OF DECEASED (Type or Print)	a. (First) Rosella	b. (Middle)	c. (Last) Clemison	4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1953
--	------------------------------	-------------	------------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept, 22, 1865	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
-------------------------	----------------------------------	--	---	--	---------------------------	--------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work when during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY In Home	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	---

13a. FATHER'S NAME Samuel Hunter	13b. MOTHER'S MAIDEN NAME Sarah Gillaspie	14. NAME OF HUSBAND OR WIFE — — —
--	---	---

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 Mrs Wayne Gonnerman	ADDRESS Fair Grove 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, 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) Orthostatic Pneumonia		One Week
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Being bedfast 12 Weeks DUE TO (c) fall + fracture left humerus		12 weeks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E9040 21			

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) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Fair Grove Greene 029 Missouri
---	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 22, 1953 ? m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell at Home
--	---	---

22. I hereby certify that I attended the deceased from **Sept 22, 1953**, to **Dec 10, 1953**, that I last saw the deceased alive on **Dec 10, 1953**, and that death occurred at **6:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wayne Gonnerman D.O.	23b. ADDRESS Fair Grove, Mo	23c. DATE SIGNED 12/10/53
---	---------------------------------------	-------------------------------------

24a. BURIAL CREMATION REMOVAL (Specify) Removal	24b. DATE Dec. 10, 53	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F.	24d. LOCATION (City, town, or county) (State) Hurdland Mo.
---	---------------------------------	---	--

DATE REC'D BY LOCAL REG. 12-12-53	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co	ADDRESS 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.....
Signature of Student Embalmer

Signed..... *Ogle Slone Jr.*

Licensed Embalmer No. *4172*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.