

FILED APR 19 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11911

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>50</u>	
1. PLACE OF DEATH a. COUNTY <u>Hawell</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Hawell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (If in this place) <u>5 1/2 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		0461	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>322 Thayer Ave</u>				d. STREET ADDRESS (If rural, give location) <u>322 Thayer Ave</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Amanda</u> b. (Middle) <u>Francis</u> c. (Last) <u>Lafavers</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 4 1954</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Feb. 8 1883</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Days <u>1</u> Months <u>26</u>		IF UNDER 24 HOURS Hours <u>1</u> Min. <u>26</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mitchell, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George W. Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Lou Hammond</u>		14. NAME OF HUSBAND OR WIFE <u>Stephen A. Lafavers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Stephen A. Lafavers, 322 Thayer Ave</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL HEMORRHAGE</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> ANTECEDENT CAUSES DUE TO (b) <u>HYPERTENSION, ESSENTIAL</u> <u>2 YEARS</u> DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>SENILITY</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>4-3 1954</u> to <u>4-4 1954</u> , that I last saw the deceased alive on <u>4-3 1954</u> , and that death occurred at <u>3:07</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. N. Wilcox M.D.</u>				23b. ADDRESS <u>West Plains, Mo.</u>		23c. DATE SIGNED <u>4-9-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-6-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pisgah Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fulton County, Ark.</u>	
DATE REC'D BY LOCAL REG. <u>4-13-54</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		379		25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Center Funeral Service - Salem, Ark.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed

*Leland Carter*

Signed.....

Student Embalmer

Licensed Embalmer No. *4516*

P. O. Address *Hayes, 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.