

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 16 1954

State File No. **269091**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5463** Registrar's No. **768**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. CITY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL JACKSON		c. CITY OR TOWN Strafford R.	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION STRAFFORD RFD # 1		e. STREET ADDRESS (If rural, give location) RT I	

3. NAME OF DECEASED a. (First) ELZ YREEN b. (Middle) IV. c. (Last) SHARICK			4. DATE OF DEATH (Month) (Day) (Year) Aug 9 - 1954		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Check one) Widowed	8. DATE OF BIRTH Jan 24-1876	9. AGE (In years last birthday) Months Days Hours Mins. 76
----------------------	-------------------------------	---	-------------------------------------	---

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 (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	--

13a. FATHER'S NAME Hal Groves	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Widowed
--------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Ralph Sharick	ADDRESS Springfield
---	--	--	----------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-Sclerotic Heart Disease		DUPLICATE		NOT KNOWN
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. By pulmonary infection. Disruption of right foot		7 DAYS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 1200	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)	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 **Aug 5, 1954**, to **Aug 9, 1954**, that I last saw the deceased alive on **Aug 6, 1954**, and that death occurred at **11:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE M. O. [Signature]	23b. ADDRESS SPRINGFIELD Mo 1711 Boonville	23c. DATE SIGNED 8-11-54
---	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-11-54	24c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery	24d. LOCATION (City, town, or county) (State) Greene Co. Mo.
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. 8-13-54	REGISTRAR'S SIGNATURE Walter Williamson	FUNERAL DIRECTOR'S SIGNATURE J. W. Rinsler	ADDRESS Springfield, Mo.
---	--	---	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

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 Stone Jr*.....

Licensed Embalmer No. *417*

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.