

FILED SEP 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30437

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>26</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). M. STATE <u>Missouri</u> <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (In this place) <u>3 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains, Missouri</u> <u>0461</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>311 S. Hill Street</u>				d. STREET ADDRESS (If rural, give location) <u>311 S. Hill Street,</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Julia</u>		b. (Middle) <u>Reba</u>		c. (Last) <u>House</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9</u> <u>4</u> <u>54</u>	
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>8-7-1898</u>	
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Birchtree, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Monroe Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Lyles</u>		14. NAME OF HUSBAND OR WIFE <u>Earl House</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Leonard Nourse Lebanon Mo</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>Carcinoma of Colon (sigmoid)</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19a. DATE OF OPERATION <u>8-6-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Mucoid Carcinoma of sigmoid Colon with metastasis</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) _____		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>6-25</u> , 19 <u>54</u> , to <u>9-4</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-1</u> , 19 <u>54</u> , and that death occurred at <u>3:45</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>E. Callihan M.D.</u> (Degree or title) <u>0</u>				23b. ADDRESS <u>WEST PLAINS, Missouri</u>		23c. DATE SIGNED <u>9-10-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>9-5-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>West Plains, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-13-54</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robertsons, West Plains, Mo.</u>			

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

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**STATEMENT BY LICENSED EMBALMER**

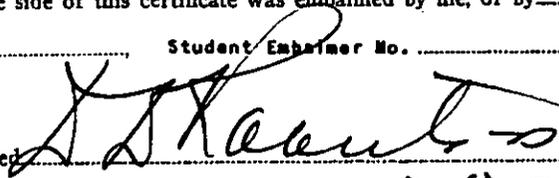
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No.

3487

P. O. Address

West Plains

**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.