

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36413

State File No.

FILED DEC 7 1954

BIRTH NO. _____ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 3002 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mexico, Mo.		c. CITY OR TOWN Centralia	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: Audrain Co. Hospital		e. STREET ADDRESS (If rural, give location) 104 West Barnes	

3. NAME OF DECEASED (Type or Print) a. (First) Rosa	b. (Middle) Lee	c. (Last) Howell	4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1954
---------------------------------------------------------------	------------------------	-------------------------	---------------------------------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 23, 1875	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 09 Days 04	IF UNDER 6 HRS. Hours Min.
----------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	-------------------------------------------------	--------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (City and State or Foreign Country) Callaway County, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
--------------------------------------------------------------------------------------------------------------	----------------------------------------------------	--------------------------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME M.S. Bush	13b. MOTHER'S MAIDEN NAME Paulina Brown	14. NAME OF HUSBAND OR WIFE
-------------------------------------	------------------------------------------------	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Goldie Lee Fulton, Mo.	ADDRESS
-----------------------------------------------------------------------------	-------------------------------------	---------------------------------------------------------------------	---------

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, ashenia, 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) Diabetes mellitus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of right femur			

19a. DATE OF OPERATION Sept 12, 1954	19b. MAJOR FINDINGS OF OPERATION Fracture right femur	20. AUTOPSY? 260 X F 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 **Sept 10, 1954** to **Nov 27, 1954**, that I last saw the deceased alive on **Nov 26, 1954**, and that death occurred at **5:00 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robt L. Ward, M.D.	23b. ADDRESS 120 N. Rollins Centralia Mo	23c. DATE SIGNED Nov 27, 1954
------------------------------------------------------------	-------------------------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov. 29, 1954	24c. NAME OF CEMETERY OR CREMATORY Centralia	24d. LOCATION (City, town, or county) (State) Centralia Mo.
----------------------------------------------------------	--------------------------------	-----------------------------------------------------	--------------------------------------------------------------------

DATE REC'D BY LOCAL REG. Nov-28-1954	REGISTRAR'S SIGNATURE Blanche Neely	25. FUNERAL HOME'S SIGNATURE Bill Meador	ADDRESS Centralia Missouri
---------------------------------------------	--------------------------------------------	-------------------------------------------------	-----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 7 1958

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 *Bill J. Meador*.....

Licensed Embalmer No. 4876

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