

FILED JUN 8 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6181 State File No. 17477

BIRTH NO. _____ REG. DIST. NO. 349 PRIMARY REG. DIST. NO. 4513 Registrar's No. 17

250
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Penn Township		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Penn Township 1050	
c. LENGTH OF STAY (In this place) 10		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) Emma		b. (Middle)		c. (Last) Bozarth		4. DATE OF DEATH Month June Day 2 Year 1955	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH May 22, 1870		9. AGE (In years last birthday) 85 IF UNDER 1 YEAR: Months 22 Days 22 Hours 0 Min. 0	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jacob Bozarth			13b. MOTHER'S MAIDEN NAME Phillipine Blythe Shafer			14. NAME OF HUSBAND OR WIFE Andrew Bozarth	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Olen True, Green Castle, Mo.			
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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						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY Sclerosis		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Arterio-sclerosis						1 YEAR	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition-causing death.		DUE TO (c)						5 YEARS	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 4201					
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 Feb 10, 1950, to June 2, 1955, that I last saw the deceased alive on Feb 2, 1955, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

23a. SIGNATURE R. D. Smith M.D. (Degree or title)			23b. ADDRESS Green City, Mo June 4, 1955			23c. DATE SIGNED		
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE June 5, 1955		24c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery		24d. LOCATION (City, town, or county) (State) Green Castle, Mo.			
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DATE REC'D BY LOCAL REG. 6-6-55		REGISTRAR'S SIGNATURE Agnes L. Page 504			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glenn E. Kenton Green City Mo				
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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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Greenville, S.C.

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.