

REC'D AUG 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21072

State File No.

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 195

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>BARTON</u>		
b. CITY OR TOWN <u>COLUMBIA 0</u>		c. LENGTH OF STAY (in this place) <u>17 DAYS</u>	c. CITY OR TOWN <u>JASPER</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>0060</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Elis FISCHEL ST. C.A. Hosp</u>			f. STREET ADDRESS (If rural, give location) <u>R.F.D # 3</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>HOUDYSHELL</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>8-1-55</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>4-6-93</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR: Months <u>3</u> Days _____
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 (City and State or Foreign Country) <u>BUTLER Co. KANSAS /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>PHILLIP HAGEN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY HAGEN</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM HOUDYSHELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HOSPITAL RECORDS</u>		

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) <u>Chronic lymphatic leukemia</u>		DUPLICATE OF (a) _____			<u>2 yrs</u>
ANTECEDENT CAUSES		DUE TO (b) _____			_____
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>2040, Adeno. Ca. of Kidney</u>			_____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____			<u>Found at autopsy</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input checked="" 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) _____	
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? _____	

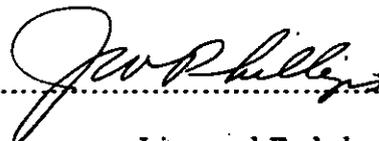
22. I hereby certify that I attended the deceased from 7-12, 1953, to 8-1, 1955, that I last saw the deceased alive on 8-1, 1953, and that death occurred at 9:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Richard E. Johnson, M.D.</u>		23b. ADDRESS <u>Columbia, Mo</u>		23c. DATE SIGNED <u>8-1-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8-1-1955</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>JASPER, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 1, 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parsons Funeral Service, Columbia Mo.</u>		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No.....

P. O. Address.....
Columb

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.