

FILED AUG 9 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22623

State File No.

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 110

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Webb City Mo</u>		c. CITY OR TOWN <u>Webb City Mo</u>	
c. LENGTH OF STAY (in this place) <u>35 yrs</u>		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 <u>311 E. Daugh. St.</u>		e. STREET ADDRESS (If rural, give location) <u>311 E. Daugh. St. 0490</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Ann</u> c. (Last) <u>Misner</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 31 1955</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Apr 13, 1874</u>		9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>18</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 (City and State or Foreign Country) <u>Rothville, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Tom Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Ralph Misner - Webb City, Mo</u>		ADDRESS			

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>Cerebral hemorrhage</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		DUE TO (c) <u>331X</u>			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) (Min)		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 July 25, 1955, to July 28, 1955, that I last saw the deceased alive on July 28, 1955, and that death occurred at 3:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J.M. Reese D.S.</u>		23b. ADDRESS <u>Cartersville, Mo</u>		23c. DATE SIGNED <u>8-4-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 2, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sarcophic Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Sarcophic Mo.</u>	

DATE REC'D BY LOCAL REG. <u>8-4-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer 4740</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Johnston Bruce - Simpson, Mortuary Webb City, Mo</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

County File No. 53-8-15
Date Filed NOV 8 1955

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 Harry E. Arnee

Licensed Embalmer No. 444
P. O. Address West City

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.