

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

30019

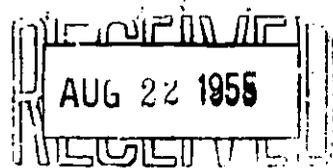
State File No. 22

FILED SEP 19 1955

BIRTH NO. _____ REG. DIST. NO. 16d PRIMARY REG. DIST. NO. 3032 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrensburg</u>		c. LENGTH OF STAY (in this place) <u>3 Days</u>	c. CITY OR TOWN <u>Norborne</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Warrensburg Medical Center</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
e. STREET ADDRESS (If rural, give location) <u>West 4th Street</u>			0 M 1	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Rodey</u> b. (Middle) <u>Zelda</u> c. (Last) <u>Laws</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 18, 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>Sept. 16, 1882</u>	
9. AGE (In years, months, days) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Mins. _____	
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 <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>		
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>James A. Laws (Deceased)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>Information</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Keith Jones, Warrensburg, Mo.</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>Diabetic Acidosis</u>		DUE TO (b) <u>Diabetes Mellitus</u>		<u>2 days</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>Intertrochanteric fracture of left hip</u>		<u>15 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Intertrochanteric fracture of left hip</u>		<u>E9040 21</u>
19a. DATE OF OPERATION <u>Aug. 17, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Intertrochanteric fracture left hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Norborne of Carroll Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8-12-55 8 P. M.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall in Home</u>	
22. I hereby certify that I attended the deceased from <u>8-12-1955</u> , to <u>8-19-1955</u> , that I last saw the deceased alive on <u>8-19-1955</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Keith D. Jones, M.D.</u>		23b. ADDRESS <u>Warrensburg, Mo.</u>		23c. DATE SIGNED <u>8-20-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 20, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Moriah</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-19-55</u>		REGISTRAR'S SIGNATURE <u>Elyse H. Bridges</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Deitch Funeral Home, Norborne, Mo.</u>

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



JOHNSON COUNTY HEALTH DEPT

MAY 14 1951

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..... *J. Earl Priest*

Licensed Embalmer No. *3878*

P. O. Address *Warrens*

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.