

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32853

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>905</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield,</u>		c. LENGTH OF STAY (in this place) <u>2 months</u>		c. CITY OR TOWN <u>Chula</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1350 S. Kimbrough</u>				e. STREET ADDRESS (If rural, give location) <u>05401</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mollie</u> b. (Middle) <u>Woods</u> c. (Last) <u>Owens</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>October 15, 1955</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>November 5, 1871</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></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 <u>In Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Alpha, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jack M. Woods</u>			13b. MOTHER'S MAIDEN NAME <u>Vina Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>William Owens</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>Mrs. Vernon Ross Springfield, Mo</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Stroke</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>334KF</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture olecranon left</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u> <u>8 weeks</u>
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) <u>Springfield Greene, Mo.</u>		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 <u>May 24, 1954</u> , <u>Oct 15, 1955</u> , that I last saw the deceased alive on <u>Aug. 27, 1955</u> , and that death occurred at <u>5:00</u> a.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>D. D. Delaney M.D.</u>			23b. ADDRESS <u>1609 Cherry St. Cottleville</u>			23c. DATE SIGNED <u>Oct 15 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Oct. 15, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Alpha, Missouri</u>		24d. LOCATION (City, town, or county) (State) <u>Alpha, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>10-17-55</u>		REGISTRAR'S SIGNATURE <u>Walter Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James Schaffert, 7 Home, Springfield, Mo.</u>			

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 *Lewis G. Schaff*.....

Licensed Embalmer No. *380*.....

P. O. Address *Springfield*.....

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.