

FILED MAR 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

9121

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 33

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, give TOWNSHIP only) OR TOWN <u>Webb City, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Webb City, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jane Chinn Hospo.</u>		Length of stay in 1b <u>15 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>732 W. Austin</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First <u>Ollieva</u> Middle <u>W. Ross</u> Last <u>Forste</u>				Month <u>March</u> Day <u>18</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1868</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</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 country) <u>Weaublean, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>F.K. Brown</u>				14. MOTHER'S MAIDEN NAME				
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.		17. INFORMANT <u>Elsie Wade</u> Address <u>Webb City, Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Debilitation and Inanition</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Medullary Failure</u> DUE TO (c) <u>Cerebral Hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 months</u> <u>3 mo. 11 da</u>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour - Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>12-7-56</u> to <u>3-18-57</u> and last saw her alive <u>alive</u> on <u>3-18-57</u> Death occurred at <u>7:25 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u> <u>2</u>				22b. ADDRESS <u>624 W. Broadway Webb City, Mo</u>		22c. DATE SIGNED <u>3/20/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/20/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Weaver Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oronogo, Mo.</u>		
24. FUNERAL DIRECTOR <u>Johnston-Arnice-Simpson Mortuary</u> Webb City Mo (Licensed Embalmer's Statement on Reverse Side)			25. DATE RECD. BY LOCAL REG. <u>3-20-57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. securing the medical certificate in the specific manner required by law.

Health,
& Welfare
Public
Service300
1-56

474

1000
County File Number
Date Filed
5-7-3-279
MAR 25 1957

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 *Jack C. Simpson*
Licensed Embalmer No. *464*

P. O. Address *Webb 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.