

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 18 1952

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY HENRY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY HENRY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton MO	
c. LENGTH OF STAY (if this place) 26 years		d. STREET ADDRESS (If rural, give location) 726 E Green 0420	
d. FULL NAME OF HOSPITAL OR INSTITUTION 726 E Green			

3. NAME OF DECEASED (Type or Print) a. (First) MISSOURI b. (Middle) BELLE c. (Last) ASHLEY			4. DATE OF DEATH (Month) (Day) (Year) Feb 8 1952		
5. SEX F		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	
8. DATE OF BIRTH 3/22/1862		9. AGE (In Years last birthday) 89		IF UNDER 1 YEAR Days 17 IF UNDER 24 HRS. Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) COOPER Co MO.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME JOSEPH ADAIR		13b. MOTHER'S MAIDEN NAME Don't know		14. NAME OF HUSBAND OR WIFE THOMAS GREEN	
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 EFFIE WEIDEMANN ADDRESS Clinton	

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) Acute broncho-pneumonia		DUE TO (b) _____			4 days
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocardial disease					Unknown

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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 **Feb 4**, 19**52**, to **Feb 8**, 19**52**, that I last saw the deceased alive on **Feb 5**, 19**52**, and that death occurred at **3 P** m., from the causes and on the date stated above.

23a. SIGNATURE S.B. Wylie M.D. (Degree or title)		23b. ADDRESS Clinton, Mo.		23c. DATE SIGNED 2/9/52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2/10/52		24c. NAME OF CEMETERY OR CREMATORY ZELCO CEM	
24d. LOCATION (City, town, or county) (State) Clinton MO		DATE REC'D BY LOCAL REG. Feb. 16-52		REGISTRAR'S SIGNATURE Florence Adair ADDRESS Clinton Mo	
25. FUNERAL DIRECTOR'S SIGNATURE J.E. Conrath		ADDRESS Clinton Mo			

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

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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
Student Embalmer

Signed

J E Conzalez

Licensed Embalmer No. 1891

P. O. Address Clinton, Mo

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 this body is not embalmed, fact should be so stated above.