

FILED JAN 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37773

BIRTH NO. _____ REG. DIST. NO. 349 PRIMARY REG. DIST. NO. 6181 Registrar's No. 1

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

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>RURAL - Penn</u>)	c. LENGTH OF STAY (In this place) <u>105</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Penn Twp. 0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>—</u>		d. STREET ADDRESS (If rural, give location) <u>Near Green City about 2 1/2 mi</u>	

3. NAME OF DECEASED (Type or Print) <u>Fannie</u>	a. (First) <u>Fannie</u>	b. (Middle) <u>Anna</u>	c. (Last) <u>Eitel</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JAN - 11 - 1949</u>
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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>Oct. 26 - 1881</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
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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 our home</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Christopher Leavengood</u>	13b. MOTHER'S MAIDEN NAME <u>Sophie Friday</u>	14. NAME OF HUSBAND OR WIFE <u>Daniel Eitel</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or <u>no</u>) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clara Gene Smith</u>	ADDRESS <u>Green City</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Malting Hemorrhage from former laceration of left breast</u>		
	ANTECEDENT CAUSES <u>carcinoma of breast</u>		
*Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>—</u>	
DUE TO (c) <u>—</u>		II. OTHER SIGNIFICANT CONDITIONS <u>170</u>	
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>excision breast 4 yr ago</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>none</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>none</u>
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22. I hereby certify that I attended the deceased from Jan 6, 1947, to Jan 12, 1949, that I last saw the deceased alive on Jan 12, 1949, and that death occurred at 10 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Guise W. Lake, D.O.</u>	23b. ADDRESS <u>Green City, Mo.</u>	23c. DATE SIGNED <u>JAN 13 - 49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 14, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Green City, Sull. Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Jan. 14, 1949</u>	REGISTRAR'S SIGNATURE <u>Laura Collett</u>	415	25. FUNERAL DIRECTOR'S SIGNATURE <u>Blum</u>	ADDRESS <u>Green City, Mo.</u>
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RECEIVED

District Health Officer No. 10

District File Number 1-49-102

Date Filed JAN 17 1949

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 _____

Karl R. Kent

Student Embalmer No. 243

working under my personal supervision.

Signed Karl R. Kent
Student Embalmer

Signed Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Stream City, 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.