

FILED FEB 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **4502**

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

BIRTH NO. _____		REG. DIST. NO. <u>120</u>		PRIMARY REG. DIST. NO. <u>4194</u>		Registrar's No. <u>6</u>	
1. PLACE OF DEATH a. COUNTY <u>Genery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Genery</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Albany</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Athens Township</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>			b. (Middle) <u>Ardelia</u>			c. (Last) <u>Steele</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 20-49</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>Feb. 7-1867</u>		9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u>		IF UNDER 1 Hrs. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Frederick Gleason</u>		13b. MOTHER'S MAIDEN NAME <u>Welia Revin</u>		14. NAME OF HUSBAND OR WIFE <u>Paris Steele</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Frank M. Cray</u> ADDRESS <u>Albany Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Hypostatic Pneumonia</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>5227</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</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>Albany, Genery, Mo.</u>		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 <u>1-18-1949</u> , to <u>1-20-1949</u> , that I last saw the deceased alive on <u>1-20-1949</u> , and that death occurred at <u>11:45pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank N. Rose M.D.</u>				23b. ADDRESS <u>Albany, Mo.</u>		23c. DATE SIGNED <u>1-23-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/23/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grandview</u>		24d. LOCATION (City, town, or county) (State) <u>Albany, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 24 49</u>		REGISTRAR'S SIGNATURE <u>Horner M. Webster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Salford Brooke</u>		ADDRESS <u>Albany Mo</u>	

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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 me

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Clifford Brooks .....

Licensed Embalmer No. 3329 .....

P. O. Address Albany MD .....

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.