

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5423

BIRTH NO. _____		REG. DIST. NO. <u>383</u>		PRIMARY REG. DIST. NO. <u>5655</u>		Registrar's No. <u>173</u>	
1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mount Vernon</u>		c. LENGTH OF STAY (In this place) <u>23 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hocoma</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Sanatorium</u>				d. STREET ADDRESS (If rural, give location) <u>Rural Route</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lela</u> b. (Middle) <u>Myrtle</u> c. (Last) <u>Verbickk</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 28 1949</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>1-18-09</u>	
9. AGE (In years last birthday) <u>40</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
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>None</u>		11. BIRTHPLACE (State or foreign country) <u>Arditta, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James C. Fare</u>			13b. MOTHER'S MAIDEN NAME <u>Colbert</u>		14. NAME OF HUSBAND OR WIFE <u>William T. Verbickk</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None known</u>		17. INFORMANT'S SIGNATURE OR NAME <u>E. McMichael, Record Clerk</u> ADDRESS <u>Mo. State San., Mt. Vernon, 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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>abt 10 yrs</u>			
ANTECEDENT CAUSES 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.							
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>2-5-49</u> , 19 <u> </u> , to <u>2-28-49</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-28-49</u> , 19 <u> </u> , and that death occurred at <u>9:25 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>C. Hellweg M.O.</u>				23b. ADDRESS <u>Mount Vernon, Missouri</u>		23c. DATE SIGNED <u>2-28-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-28-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>West Plains Mo</u>		24d. LOCATION (City, town, or county) (State) <u>Mo</u>	
DATE REC'D BY LOCAL REG. <u>3-2-49</u>		REGISTRAR'S SIGNATURE <u>Paul Handrick</u>		411		25. FUNERAL DIRECTOR'S SIGNATURE <u>Max L. Jossitt</u> ADDRESS <u>W. Vernon, Mo</u>	

RECEIVED

District Health Officer, No. 3

District File Number 349-226

Date Filed 3-3-49

MAR 9 1949

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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.

Signed _____

May J. Joseph

Signed _____

Student Embalmer

Licensed Embalmer No. 4252

P. O. Address W. W. Warner, Inc.

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.