

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9021

Registration District No. 175

Primary Registration District No. 30.36

Registrar's No. 37

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Aurora  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Aurora Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hours 0  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Lawrence  
(c) City or town Aurora  
(If outside city or town limits, write "RURAL")  
(d) Street No. City Hosp  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Phoebe Carol Gwynn  
3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month 2 - 25 - 49 day \_\_\_\_\_  
year \_\_\_\_\_ hour 1 minute 15 P.M.

4. Sex Fe 5. Color or race W  
6. (a) Single, widowed, married, divorced 10  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased: Feb - 25 - 1949  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
0 0 0 2 hr. \_\_\_\_\_ min.

Immediate cause of death:  
① premature  
② Respiratory failure  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace: Aurora Mo  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
Major findings: 17 7/8 X

10. Usual occupation Infant

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Robert Gwynn  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Tolly Gwynn  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Robert Gwynn  
(b) Address M. Vernon, Mo.  
17. (a) Burial (b) Date thereof Feb 26 1949  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation City Cemetery M. Vernon, Mo.  
18. (a) Signature of funeral director W. A. Forrest  
(b) Address M. Vernon, Mo.  
19. (a) Apr. 2 - 49 (b) Ora Mc Natt  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature J. McCallum (M. D. or other) M.D.  
Address 134 Olive St. Aurora Date Feb 26/49

RECEIVED

District Health Officer No. 6,

District File Number 449-405

Date Filed 4-6-49

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Max J. Fossett

Licensed Embalmer No. 4252

P. O. Address McKernon, 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.