

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15601**

BIRTH NO. _____ REG. DIST. NO. **138** PRIMARY REG. DIST. NO. **2000** Registrar's No. **476**

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

39
26

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Springfield)		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (In this place) 50 years		d. STREET ADDRESS (If rural, give location) 2019 W. Phelps Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) BERTIE b. (Middle) GOLDIE c. (Last) WOOD			4. DATE OF DEATH (Month) (Day) (Year) May 28, 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Nov. 8, 1896
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State of foreign country) Boliver, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Clabe Stone		13b. MOTHER'S MAIDEN NAME Mahaley Coble	
14. NAME OF HUSBAND OR WIFE Cal Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NUMBER 491-03-2904	
17. INFORMANT'S SIGNATURE OR NAME Glenn Wood		ADDRESS Albuquerque, N.M.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subhepatic Abscess ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Infection from Biliary Tract after cholecystomy 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 May 28, 1949		19b. MAJOR FINDINGS OF OPERATION destruction of the Bill ducts from Abscess	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 June 7, 1948 , to May 28, 1949 , that I last saw the deceased alive on May 28, 1949 , and that death occurred at 5:03P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Gene W. Farthing M.D. (M)		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED 5/31/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 31, 1949	
24c. NAME OF CEMETERY OR CREMATOR Greenlawn		24d. LOCATION (City, town, or county) (State) Walnut Grove, Mo.	
DATE REC'D BY LOCAL REG. 5/31/49		REGISTRAR'S SIGNATURE W.E. Handley M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Frank C. Thorne		ADDRESS Springfield, Mo.	

JUN 10 1940

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.....

Ralph H. Thiem

Signed.....
Student Embalmer

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.