

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18319

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 340 | | PRIMARY REG. DIST. NO. 3075 | | Registrar's No. 26 | |
| 1. PLACE OF DEATH a. COUNTY Stoddard | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Stoddard | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) Dexter | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) Dexter | | d. STREET ADDRESS (If rural, give location) 1402 Ray Street | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | | d. STREET ADDRESS (If rural, give location) 1402 Ray Street | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Barbara | | b. (Middle) Jean | | c. (Last) Givens | | 4. DATE OF DEATH (Month) (Day) (Year) May 1, 1949 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | | 8. DATE OF BIRTH Nov. 13, 1946 | |
| 9. AGE (In years last birthday) 2 | | IF UNDER 1 YEAR Months 5 Days 17 | | IF UNDER 1 HR. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Dexter, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13a. FATHER'S NAME C. W. Givens | | | 13b. MOTHER'S MAIDEN NAME Bernice Link | | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS C. W. Givens Dexter, Mo. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture and crushed chest | | II. OTHER SIGNIFICANT CONDITIONS | | | | Sudden | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES | | | | 5812X | |
| DUE TO (b) being run over by automobile | | DUE TO (c) | | | | 25 | |
| 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 checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Dexter Stoddard Mo. | | 3 | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) May 1, 1949 9A-M. | | 21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Run over by automobile | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9 A. m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Clay W. Rainey Coroner | | | | 23b. ADDRESS Dexter, Missouri | | 23c. DATE SIGNED 5-1-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 5-2-49 | | 24c. NAME OF CEMETERY OR CREMATORY Dexter | | 24d. LOCATION (City, town, or county) (State) Dexter, Missouri | |
| DATE REC'D BY LOCAL REG. 5-10-1949 | | REGISTRAR'S SIGNATURE Velma P. Jarbo | | 25. FUNERAL DIRECTOR'S SIGNATURE Strickland-Rainey | | ADDRESS Dexter | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No. 2,
District File Number 549-594
Date Filed 5-18-49

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 _____

Signed _____
Student Embalmer

Licensed Embalmer No. 3479

P. O. Address Heyley, 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.