

FILED JUN 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19245

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 545

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

1. PLACE OF DEATH  
a. COUNTY **GREENE**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE **MISSOURI** b. COUNTY **FOLK**

b. CITY (If outside corporate limits, write RURAL and give township) **South Campbell** c. LENGTH OF STAY (In this place) **18 days**

c. CITY (If outside corporate limits, write RURAL and give township) **WES LOUISBURG** 84

d. FULL NAME OF HOSPITAL OR INSTITUTION **OZARK OSTEOPATHIC HOSPITAL** d. STREET ADDRESS (If rural, give location) **Box 49 R.R. 1, 8**

3. NAME OF DECEASED (Type or Print) **NORA AMBIT** c. (Last) **SPEAR** 4. DATE OF DEATH (Month) (Day) (Year) **6-18-49**

5. SEX **F** 6. COLOR OR RACE **WHITE** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **MARRIED** 8. DATE OF BIRTH **9/14/1902** 9. AGE (In years last birthday) **47** **4** **4** **4** IF UNDER 1 YEAR **4** IF UNDER 1 MIN. **4**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE** 10b. KIND OF BUSINESS OR INDUSTRY **House Work** 11. BIRTHPLACE (State or foreign country) **ELVIN, OREGON, USA** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **MARION L. HARRIS ARIZONA** 13b. MOTHER'S MAIDEN NAME **MARION** 14. NAME OF HUSBAND OR WIFE **JOSEPH EDWARD SPEAR**

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 **J. E. Spear** ADDRESS **Friestown, Mo.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Sepsis**

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) **Generalized Purulent peritonitis**

DUE TO (c) **Paralytic ileus**

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH **5701**

19a. DATE OF OPERATION **6/1/49** 19b. MAJOR FINDINGS OF OPERATION **Partial bowel obstruction involving the duodenum** 20. AUTOPSY?  **Yes**

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) (Min.) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from **6/1/49** to **6/18/49**, that I last saw the deceased alive on **6/18/49**, and that death occurred at **5:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Delandia Wetzel** 23b. ADDRESS **Box 2 Springfield, Mo.** 23c. DATE SIGNED **6/18/49**

24a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 24b. DATE **6/18/49** 24c. NAME OF CEMETERY OR CREMATOR **Woodley Creek Cemetery** 24d. LOCATION (City, town, or county) (State) **Near Fanning, Mo.**

DATE REC'D BY LOCAL REG. **6-21-49** REGISTRAR'S SIGNATURE **W.S. Hundley** 25. FUNERAL DIRECTOR'S SIGNATURE **Blue Bellows** ADDRESS **Blue Bellows, Mo.**

**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 \_\_\_\_\_

*William B. Brown*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 3092

P. O. Address Bolivar, 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.