

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19941

FILED JUN 22 1949

BIRTH NO. _____		REG. DIST. NO. 154		PRIMARY REG. DIST. NO. 5575		Registrar's No. 21			
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON					
b. CITY (If outside corporate limits, write RURAL, and give town) HICKMAN MILLS		c. LENGTH OF STAY (in this place) 30		c. CITY (If outside corporate limits, write RURAL and give township) 48 OR TOWN HICKMAN MILLS.					
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0					
3. NAME OF DECEASED (Type or Print) NELLIE		a. (First)		b. (Middle) S.		c. (Last) WARD.			
4. DATE OF DEATH		Month		Day		Year			
JUNE		7		1949					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH JULY-12-1874			
9. AGE (in years last birthday) 72		IF UNDER 1 YEAR Months		IF UNDER 12 HRS. Hours		Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) LATHROP, MO			
12. CITIZEN OF WHAT COUNTRY U.S.			13a. FATHER'S NAME LANGDON S. COLE		13b. MOTHER'S MAIDEN NAME CATHERINE OWENS		14. NAME OF HUSBAND OR WIFE Deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 487-07-9426		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Rosalie Ward Burns.					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Co of right ear ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) High water into both lungs DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 yr	
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)		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)		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 8-18, 1948, to 6-7, 1949, that I last saw the deceased alive on 6-7, 1949, and that death occurred at 5:00 P.M. from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) [Signature]				23b. ADDRESS [Address]		23c. DATE SIGNED 6-7-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6-9-49		24c. NAME OF CEMETERY OR CREMATORY LATHROP CEMETERY		24d. LOCATION (City, town, or county) (State) LATHROP MO			
DATE REC'D BY LOCAL REG. 6/13/49		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS DeMoss CRUNK CAMERON, MO			

(Licensed Embalmer's Statement on Reverse Side)

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

4800

**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. 3645

P. O. Address Grandview 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.