

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED NOV 5 1949

State File No. **33290**

BIRTH NO. _____ REG. DIST. NO. **65** PRIMARY REG. DIST. NO. **4114** Registrar's No. **43**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)	
a. COUNTY Chariton	b. CITY (If outside corporate limits, write RURAL and give township) Mendon	a. STATE MO	b. COUNTY Chariton
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Mendon	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) Flora Pearl Willis			4. DATE OF DEATH (Month) (Day) (Year) Oct 16-1949		
a. (First)	b. (Middle)	c. (Last)			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 4-1885	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 6 Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Williamsburg, Iowa	
12. CITIZENSHIP OF WHAT COUNTRY?					

13a. FATHER'S NAME SAM Hotchkiss	13b. MOTHER'S MAIDEN NAME Gelia Dodge	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Leroy Palmer Brookfield Mo	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 151X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach		
	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)	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 **September, 1948, to Oct 14, 1949**, that I last saw the deceased alive on **Oct 15, 1949**, and that death occurred at **10:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. W. H. Payne D.O.	23b. ADDRESS Mendon Mo.	23c. DATE SIGNED Oct. 18-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/18/49	24c. NAME OF CEMETERY OR CREMATORY Mendon	24d. LOCATION (City, town, or county) (State) Mendon MO
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DATE REC'D BY LOCAL REG. 10/18-49	REGISTRAR'S SIGNATURE Mildred Bonnell	56	25. FUNERAL DIRECTOR'S SIGNATURE L. Shepard	ADDRESS Mendon MO
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.49
210

OCT 31
RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 11-4-49

NOV 7 1949

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.

Student _____
Student Embalmer

Signed S. L. Lipard

Licensed Embalmer No. 3970

P. O. Address Mendon 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.