

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36809**

BIRTH NO. _____ REG. DIST. NO. 108 PRIMARY REG. DIST. NO. 2473 Registrar's No. 22

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

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dunklin</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Arbyrd, Rte 1 Salem</u> | | c. LENGTH OF STAY (In this place) <u>12 yrs</u> | |
| c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Arbyrd, Rte 1 Salem</u> | | d. STREET ADDRESS (If rural, give location) _____ | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | | |

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|--|-------------------------------|---|--------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or Print) | | a. (First) <u>MARY</u> | b. (Middle) <u>ELLEN</u> | c. (Last) <u>WRIGHT</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 15th 1949</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u> | | 8. DATE OF BIRTH <u>June 12 1880</u> | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>Evansville, Ind</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME <u>Clay Rowe</u> | | 13b. MOTHER'S MAIDEN NAME <u>unobtainable</u> | | 14. NAME OF HUSBAND OR WIFE _____ | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Walter Wilborn</u> ADDRESS <u>Arbyrd, Mo.</u> | |

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|--|--|---|--|--|----------------------------------|
| 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) <u>Hypertensive Heart Disease</u> | | DUE TO (b) <u>Hypertension + senility</u> | | | <u>1 mo</u> |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | DUE TO (c) _____ | | | <u>10 yrs</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | <u>44 3/4</u> |

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|--|--|--|--|--|--|
| 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) <u>Sept 20 49</u> 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 20 SEPT, 1949, to 15 OCT, 1949, that I last saw the deceased alive on 15 Oct, 1949, and that death occurred at 4 P. m., from the causes and on the date stated above.

| | | | | | |
|---|--|-------------------------------------|--|--|--|
| 23a. SIGNATURE (Degree or title) <u>T N Rodman M.D.</u> | | 23b. ADDRESS <u>Leachville, Ark</u> | | 23c. DATE SIGNED <u>2 Nov 49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>10/17/49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Gravel Hill</u> | |
| | | | | 24d. LOCATION (City, town, or county) (State) <u>Bloomfield, MO.</u> | |

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|--|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. <u>11-12-49</u> | | REGISTRAR'S SIGNATURE <u>Mrs J H Lane</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Turner Service</u> ADDRESS <u>Leachville, Ark</u> | |
|--|--|---|--|--|--|

RECEIVED NOV 25 194
District Health Office No.
District File Number 1149-118
Date Filed _____

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 _____

H. H. Howard

Signed _____

Student Embalmer

Licensed Embalmer No. _____

3959

P. O. Address _____

Leachville, Ark.

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.