

FILED DEC 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37458
State File No. 5033

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

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5033

1. PLACE OF DEATH
a. COUNTY Franklin, Mo.
b. CITY (If outside corporate limits, write RURAL and give town) Trinity Lutheran Hospital
c. LENGTH OF STAY (in this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Kansas
b. COUNTY Miami
c. CITY (If outside corporate limits, write RURAL and give township) Osawatomie, Kansas
d. STREET ADDRESS (If rural, give location) 333 E. Pacific

3. NAME OF DECEASED
a. (First) Mrs. Gladys M. Prentice
b. (Middle) _____
c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year)
11-24-49

5. SEX Female 6. COLOR OF RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH May 20-1896 9. AGE (In years last birthday) 53 IF UNDER 1 YEAR Months 6 Days 4 IF UNDER 24 HRS. Hours 2 Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Ray Browning 13b. MOTHER'S MAIDEN NAME Emma Deane 14. NAME OF HUSBAND OR WIFE Frank L. Prentice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Frank L. Prentice ADDRESS Osawatomie Mo.

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of large ovarian cyst
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ovarian cyst
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS: Stimic - complete anorexia
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 175X

19a. DATE OF OPERATION 11-17-49 19b. MAJOR FINDINGS OF OPERATION Large ovarian cyst - acute hemorrhage into cyst 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Nov. 6, 1949, to Nov. 24, 1949, that I last saw the deceased alive on Nov. 24, 1949, and that death occurred at 11:52 m., from the causes and on the date stated above.

23. SIGNATURE Geo. H. Norberg (Degree or title) M.D. 23b. ADDRESS 537 East 54th St. R. C. Mo. 23c. DATE SIGNED _____

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 11/24/49 24c. NAME OF CEMETERY OR CREMATORY New Osawatomie 24d. LOCATION (City, town, or county) (State) Osawatomie Kansas

DATE REC'D BY, LOCAL REG. 11-26-49 REGISTRAR'S SIGNATURE Geraldine Holmes 25. FUNERAL DIRECTOR'S SIGNATURE Norman W. Eddy ADDRESS Osawatomie Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 *William H. Day*.....
Licensed Embalmer No. *1659*.....

P. O. Address *Quinton, Va.*.....

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.