

FILED JAN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40824**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1168**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN SPRINGFIELD	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2103 N. ROBBERTSON		d. STREET ADDRESS (If rural, give location) 2103 N. ROBBERTSON	

3. NAME OF DECEASED (Type or Print)	a. (First) NANCY	b. (Middle) JANE	c. (Last) MARTIN	4. DATE OF DEATH (Month) (Day) (Year) DEC. 30 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 23 DEC. 1871	9. AGE (In years last birthday) 78	# UNDER 1 YEAR Months Days	# UNDER 6 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY IN HOME	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME ?	13b. MOTHER'S MAIDEN NAME LUPTON UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) No	17. INFORMANT'S SIGNATURE OR NAME LEO FATH	ADDRESS SPGFD. MO.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebro-Renal-Vascular Decline		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		442X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from _____, 1946, to **12-30, 1949**, that I last saw the deceased alive on **12-23, 1949**, and that death occurred at **5:45 am**, from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) Max Fath	(Thorough title) M.D.	23b. ADDRESS Springfield Mo.	23c. DATE SIGNED 1-3-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-3-50	24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	24d. LOCATION (City, town, or county) (State) SPRINGFIELD MO.
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DATE REC'D BY LOCAL REG. 1-3-50	REGISTRAR'S SIGNATURE W.E. Handley M.D.	FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co.	ADDRESS Spfgd. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Max Rhodes

Signed.....
Student Embalmer

Licensed Embalmer No. 4071

P. O. Address Springfield

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.