

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40869
State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 1134

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pack #11</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - South Campbell Twp.</u>		c. LENGTH OF STAY (in this place) <u>2 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Pack Aldrich</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>OZARK OSTEOPATHIC HOSPITAL</u>			d. STREET ADDRESS (If rural, give location) <u>rural P#1</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>MINNIE</u> b. (Middle) <u>MAYE</u> c. (Last) <u>HAGAR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-21-49</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>MAY 3, 1893</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ALBERT MADDEN</u>	13b. MOTHER'S MAIDEN NAME <u>JANE DRIVER</u>	14. NAME OF HUSBAND OR WIFE <u>EDD. HAGAR</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>DREN TAYLOR</u>	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal Obstruction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Primary Carcinoma of Uterus</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>174X</u>	

19a. DATE OF OPERATION <u>12/19/49</u>	19b. MAJOR FINDINGS OF OPERATION <u>extensive metastatic carcinoma</u>	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) (Min.) _____	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 12-19, 1949, to 12-21, 1949 and that I last saw the deceased alive on 12-21, 1949, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R. C. Michael D.O.</u>	23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>12/21/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>12-24-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MITCHELL CAMP GROUP</u>	24d. LOCATION (City, town, or county) (State) <u>Pack Co. MO</u>
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DATE REC'D BY LOCAL REG. <u>12-23-49</u>	REGISTRAR'S SIGNATURE <u>W. E. Hoadley</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>BRIM FUNERAL SERVICE</u>	ADDRESS <u>Walnut Grove MO</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 10 1956

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..... *Warren D. Hoblett*

Signed.....
Student Embalmer

Licensed Embalmer No. *4005*

P. O. Address *Ash Grove 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.