

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43931**

Registrar's No. **238**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wardell	
c. LENGTH OF STAY (in this place) 3 days		d. STREET ADDRESS (If rural, give location) R. R. 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) Nancy	b. (Middle) Mae	c. (Last) Montgomery	4. DATE OF DEATH (Month) (Day) (Year) Dec. 26, 1949
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5. SEX Female	6. COLOR OR RACE NegDD	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH X	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of speaking life, even if retired) House-wife	10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (State or foreign country) Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Crow Montgomery
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME Crow Montgomery ADDRESS Wardell, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction with Gangrene		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Post-operative Adhesions DUE TO (c) None		
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"/>
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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) 57A.5
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 **12-25**, 1949, to **12-26**, 1949, that I last saw the deceased alive on **12-26**, 1949, and that death occurred at **7:30 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Montague Lawrence's	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 1-3-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-28-49	24c. NAME OF CEMETERY OR CREMATORY Wardell	24d. LOCATION (City, town, or county) (State) Wardell, Mo.
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DATE REC'D BY LOCAL REG. JAN 10 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Jimmy Osburn ADDRESS Wardell, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 26 1950

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 _____

James A. Osburn

Licensed Embalmer No. *4185*

P. O. Address *Wardell, 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.