

FILED FEB 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43966

BIRTH NO. _____ REG. DIST. NO. 339 DELAYED PRIMARY REG. DIST. NO. 6150 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY Stoddard			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard		
b. CITY (If outside corporate limits, write RURAL and give township) Rural New Lisborn T.S.		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Rural New Lisborn T.S.		1030
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED (Type or Print) Amanda		a. (First)	b. (Middle)	c. (Last) Townsend	4. DATE OF DEATH 3 21 1949	
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 19 1895	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months 11	IF UNDER 1 YEAR Days 2	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS* OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Miriam Illinois /		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME Newton Phelps		13b. MOTHER'S MAIDEN NAME No Data		14. NAME OF HUSBAND OR WIFE Oliver Townsend	
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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 ADDRESS Oliver Townsend Kinder 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4222	

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 _____, 1948, to 3-21, 1949 that I last saw the deceased alive on 3-20, 1949 and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE E. C. Mestres		(Degree or title) DO, 2		23b. ADDRESS Advance Mo.		23c. DATE SIGNED 12-30-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-23-49	24c. NAME OF CEMETERY OR CREMATORY Fagan		24d. LOCATION (City, town, or county) (State) Rural New Lisborn T.S.	
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DATE REC'D BY LOCAL REG. 1-18-50		REGISTRAR'S SIGNATURE Blond Morgan		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. W. ...	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED FEB 6 1951

District Health Office No. 2

District File Number 250-1

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.

Student
Student Embalmer

Signed

Lynnan Steele

Licensed Embalmer No. 2476

P. O. Address *Nexter 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.