

FILED JAN 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

165

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>9</u>			
1. PLACE OF DEATH a. COUNTY <u>BOONE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>COLUMBIA</u>		c. LENGTH OF STAY (in this place) <u>62 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Versailles</u>		1 <u>0710</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Ellis Fischell State Hospl</u>				d. STREET ADDRESS (If rural, give location) <u>RFD 2</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>			b. (Middle) <u>Ann</u>		c. (Last) <u>Otten</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 14 50</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>Feb 17 1872</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u>27</u> Min.		
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>XX</u>		11. BIRTHPLACE (State or foreign country) <u>Gravois Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>CHARLES COOPER</u>			13b. MOTHER'S MAIDEN NAME <u>REBECCA BAILEY</u>			14. NAME OF HUSBAND OR WIFE <u>CHARLIE OTTEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL RECORD</u>		ADDRESS <u>COLUMBIA</u>			
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) <u>Lymphoepithelioma left tonsil</u> ANTECEDENT CAUSES <u>with cervical metastasis</u> 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.				INTERVAL BETWEEN ONSET AND DEATH <u>145X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Nov 7, 1949</u> , to <u>Jan 14, 1950</u> that I last saw the deceased alive on <u>Jan 13, 1950</u> , and that death occurred at <u>645A m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Jerry H. Allen</u>				23b. ADDRESS <u>M.O. Ellis Fischell Hospl</u>		23c. DATE SIGNED <u>Jan 14-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 16-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Versailles</u>		24d. LOCATION (City, town, or county) (State) <u>Versailles Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Jan 15 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Powell</u>		ADDRESS <u>Columbia Mo</u>			

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

District File Number _____
RECEIVED JAN 23 1950
District Health Officer No. 9,

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.....
Student Embalmer

Signed

Lyman H. Sprinkle

Licensed Embalmer No. *4213*

P. O. Address *Columbia, 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.