

FILED FEB 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 180

BIRTH NO. _____ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 4049 Registrar's No. 12

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Centralia Mo</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Centralia Mo-0100</u> | |
| c. LENGTH OF STAY (in this place) <u>6 Mo</u> | | d. STREET ADDRESS (If rural, give location) _____ | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Way Nursing Home</u> | | | |

| | | | |
|---|-------------------------------|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>HETTIE</u> b. (Middle) <u>A</u> c. (Last) <u>BLACK</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>FEB - 2 - 1950</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u> | 8. DATE OF BIRTH <u>Sept - 1 - 1867</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (State or foreign country) <u>Millerburg - Mo U.S.A.</u> |
| 12. CITIZEN OF WHAT COUNTRY _____ | | 13. FATHER'S NAME <u>George W Smith</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>DIS</u> | | 14. NAME OF HUSBAND <u>J. W. Black</u> | |

| | | | |
|---|-------------------------------|---|--|
| 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>Stanley Black - St Louis</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, asthenia, etc. It means the disease, injury, or complication which caused death. | | 19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>Life</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>none</u> DUE TO (c) <u>none</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

| | | |
|---|--|--|
| 19a. DATE OF OPERATION <u>None</u> | 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) _____ | 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 1925, 1925, to 2/2/50, that I last saw the deceased alive on Jan. 31, 1950, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

| | | |
|---|----------------------------------|--------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u> | 23b. ADDRESS <u>Centralia Mo</u> | 23c. DATE SIGNED <u>2/3/50</u> |
|---|----------------------------------|--------------------------------|

| | | | |
|---|---|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Feb - 4 - 1950</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Westminster</u> | 24d. LOCATION (City, town, or county) (State) <u>near Hatter Mo.</u> |
| DATE REC'D BY LOCAL REG. <u>Feb. 3 - 1950</u> | REGISTRAR'S SIGNATURE <u>Maud McBride</u> | GENERAL DIRECTOR'S SIGNATURE <u>Gene Jerome</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
FEB 6 1937
District Health Officer No. 9,
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.

Student
Student Embalmer

Signed Frank Jernigan

Licensed Embalmer No. 4270

P. O. Address Centerville, 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.