

FILED FEB 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5224

5224

0821  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3054</u>		Registrar's No. <u>201</u>	
1. PLACE OF DEATH a. COUNTY <u>PIKE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LOUISIANA</u>		c. LENGTH OF STAY (in this place) <u>WIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LOUISIANA</u>		0821	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>PIKE COUNTY HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>411 1/2 GEORGIA ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALTHEA</u> b. (Middle) <u>ELNORA</u> c. (Last) <u>WAITE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 14, 1950</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept 1, 1868</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Days <u>5</u> Hours <u>13</u>		IF UNDER 2 HRS. Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Factory Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>T.G. SNEAD</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH MOSS</u>		14. NAME OF HUSBAND OR WIFE <u>EDWIN R. WAITE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. John Becker</u> ADDRESS <u>Bowling Green, Mo.</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>Hypertensive Cardiovascular Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Due to (b) Bronchopneumonia + Pulmonary Congestion</u> 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>3 days</u> <u>7143 X</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) _____ m.		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>2-10, 1950</u> , to <u>2-14, 1950</u> , that I last saw the deceased alive on <u>2-13, 1950</u> , and that death occurred at <u>8:10 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Chas H. Lewellen</u> (Degree or title) <u>MD.</u>				23b. ADDRESS <u>Louisiana, Mo.</u>		23c. DATE SIGNED <u>2-15-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 16, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Louisiana, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 15, 1950</u>		REGISTRAR'S SIGNATURE <u>Bonnie Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Haley Mortuary</u> ADDRESS <u>Louisiana, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

FEB 23 1950

District Health Officer No.

District File Number 5-28-

Date Filed FEB 23 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.....

work under my personal supervision.

Student Embalmer No.....

Signed *Geo. M. Collier*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3839

P. O. Address Louisiana, 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.