

FILED APR 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12642

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 345-A

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place) 1 year	
d. FULL NAME OF HOSPITAL OR INSTITUTION 519 Cherry		d. STREET ADDRESS (If rural, give location) 519 Cherry	
3. NAME OF DECEASED (Type or Print) Rose		a. (First) b. (Middle) Brower	
c. (Last) Sobotka		4. DATE OF DEATH (Month) (Day) (Year) April 12 1950	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 4, 1877	
9. AGE (In years last birthday) 73		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Cainsville, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Brower		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs Russell Lynch, Republic, Missouri	
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) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertensive and Arteriosclerotic Heart disease</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. <u>None</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE HOMICIDE <u>None</u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Republic, Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>None</u>		22. I hereby certify that I attended the deceased from <u>July 6, 1949</u> , to <u>April 12, 1950</u> , that I last saw the deceased alive on <u>April 12, 1950</u> , and that death occurred at <u>6:55 P.</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>John G. Each, M.D.</u>		23b. ADDRESS <u>Republic, Mo.</u>	
23c. DATE SIGNED <u>4/14/50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>April 13, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cainsville</u>	
24d. LOCATION (City, town, or county) (State) <u>Cainsville, Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.E. Handley M.D., Alma Schmeiser, Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-17-50</u>		ADDRESS <u>B.F.W.</u>	

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 Bernard F Wright

Licensed Embalmer No. 42,93

P. O. Address Springfield

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.