

FILED MAY 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16496**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **469**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Greenfield	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION. St. John's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) David	b. (Middle) R	c. (Last) White	4. DATE OF DEATH (Month) (Day) (Year) May 16, 1950
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5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 4 1863	9. AGE (In years last birthday) 86	# UNDER 1 YEAR 5	1 YEAR 12	# UNDER 1 HR. 	1 HR. 	MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Merchant	11. BIRTHPLACE (State or foreign country) Unkown	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unkown	13b. MOTHER'S MAIDEN NAME Unkown	14. NAME OF HUSBAND OR WIFE Hetty Shackelford
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Howard Wetzwl	ADDRESS Greenfield 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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uræmia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cli. nephritis DUE TO (c) Scirrhosis Enlarged prostate gland causing obstruction		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 5-15-50	19b. MAJOR FINDINGS OF OPERATION Bronchopneumonia, peritonitis, etc.	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., tp or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) 592X (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 **May 10, 1950**, to **May 16, 1950**, that I last saw the deceased alive on **5-16, 1950**, and that death occurred at **1:30 am.**, from the causes and on the date stated above.

23a. SIGNATURE W. R. Allison (Degree or title)	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 5-15-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 18, 1950	24c. NAME OF CEMETERY OR CREMATORY Greenfield	24d. LOCATION (City, town, or county) (State) Greenfield Mo
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DATE REC'D BY LOCAL REG. 5-19-50	REGISTRAR'S SIGNATURE W. E. Haubly	25. FUNERAL DIRECTOR'S SIGNATURE W. R. Allison	ADDRESS Greenfield Mo
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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..... *W.R. Allison*

Signed.....
Student Embalmer

Licensed Embalmer No. *4404*

P. O. Address *Greenfield, 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.