

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23139

State File No.

FILED AUG 7 1950

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5354 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY OR TOWN <u>Oliver Rural</u> c. LENGTH OF STAY (in this place) <u>24 yrs</u>		c. CITY OR TOWN <u>Oliver Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0300</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ARCH</u> b. (Middle) <u>LEE</u> c. (Last) <u>DELOZIER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-6-1950</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>widowed</u>	8. DATE OF BIRTH <u>10-24-1881</u>	9. AGE (In years last birthday) <u>68</u>	# WEEKS 12 Months <u>8</u> Days <u>12</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Leaville Mo.</u>	
12a. FATHER'S NAME <u>Crum Delozier</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Hendricks</u>		14. NAME OF HUSBAND OR WIFE <u>Mollie</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>Tom Delozier</u> ADDRESS <u>Chelton, Mo.</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cornary Thrombosis</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>A. Blum</u> (Degree or title) <u>5</u>	23b. ADDRESS <u>Buffalo Mo</u>	23c. DATE SIGNED <u>7-7-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-12-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St Luke</u>	24d. LOCATION (City, town, or county) (State) <u>Marshfield Mo</u>
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DATE REC'D BY LOCAL REG. <u>7/22/50</u>	REGISTRAR'S SIGNATURE <u>Mrs J. B. Jones</u> ADDRESS <u>80 Buffalo Mo</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>L B Jones</u> ADDRESS <u>Buffalo Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED JUL 25 1950

Dist. File ~~750~~ 750-893

Date Filed 7-31-50

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 Morris B Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo 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.