

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23249

State File No. 23249
Registrar's No. 684

FILED AUG 7 1950

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION 846 So. Roanoke		d. STREET ADDRESS (If rural, give location) 846 So. Roanoke	

3. NAME OF DECEASED (Type or Print)	a. (First) DELIA	b. (Middle)	c. (Last) ANTHONY	4. DATE OF DEATH (Month) (Day) (Year)
				July 30, 1950

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 2, 1870	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	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 Unknown	11. BIRTHPLACE (State or foreign country) Milsad, Texas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME J. R. Yerion	13b. MOTHER'S MAIDEN NAME Isabella Wall	14. NAME OF HUSBAND OR WIFE XX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Allene Robberson, Springfield, Mo.	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4521
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-Vascular Disease		
	DUE TO (c)		
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 checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT <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 Jan., 1950, to July 30, 1950, that I last saw the deceased alive on July 29, 1950, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Ronald F. Etkin M.D.	23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 7-31-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 1, 1950	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
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DATE REC'D BY LOCAL REG. 8-2-50	REGISTRAR'S SIGNATURE W.E. Haulby M.D.	25. FUNERAL DIRECTOR'S SIGNATURE H. H. Lohmeyer, Springfield, Missouri	ADDRESS
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

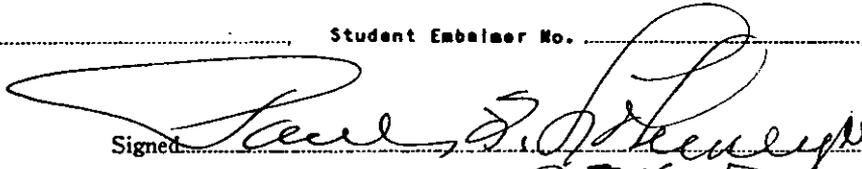
STATEMENT BY LICENSED EMBALMER

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.....

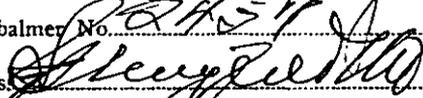


Signed.....

Student Embalmer

Licensed Embalmer No.

P. O. Address.....



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.