

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26574

State File No. _____

FILED SEP 11 1950

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 995

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 town) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION 520 E. Lynn		d. STREET ADDRESS (If rural, give location) 520 E. Lynn	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Verda	b. (Middle) Merica	c. (Last) Gafner	(Month) Sept.	(Day) 5	(Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 29 1889		9. AGE (In years (last birthday) 60) IF UNDER 1 YEAR Months 0 IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Home		11. BIRTHPLACE (State or foreign country) Ark.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Robert Drumwright		13b. MOTHER'S MAIDEN NAME Mahalia Hicks		14. NAME OF HUSBAND OR WIFE Chris Gafner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Chris Gafner Springfield Mo	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Bile ducts		INTERVAL BETWEEN ONSET AND DEATH unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Biliary obstruction DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			155X

19a. DATE OF OPERATION 7/6/50		19b. MAJOR FINDINGS OF OPERATION Carcinoma of bile ducts		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) (Min.)		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 July 26, 1950, to Sept 5, 1950, that I last saw the deceased alive on July 4, 1950, and that death occurred at 5:45a m., from the causes and on the date stated above.

23a. SIGNATURE Robert Gafner (Degree or title)		23b. ADDRESS Mo Springfield		23c. DATE SIGNED 9/6/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9-7-50		24c. NAME OF CEMETERY OR CREMATORY GreenLawn Cemetery	
24d. LOCATION (City, town, or county) (State) Springfield Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Klingner & Co. Springfield.			
DATE REC'D BY LOCAL REG. 9-7-50		REGISTRAR'S SIGNATURE W E Handley wido			

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

0396

1396

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 Ogle Stone Jr

Licensed Embalmer No. 4176

Signed _____
Student Embalmer

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.