

No. 300
10. 48

FILED OCT 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30073**
Registrar's No. **850**

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BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 850	
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 OR TOWN Springfield)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) 0376 OR TOWN Springfield 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION Harrison Rest Home				d. STREET ADDRESS (If rural, give location) 936 N. Main			
3. NAME OF DECEASED (Type or Print) a. (First) Elizira			b. (Middle) F.		c. (Last) Woody		4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Sept. 23, 1869	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Wesley Clemmons			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE DECEASED		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Mrs. JOHN AUERS		ADDRESS 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia hypostatic. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Cardio-Vascular - Renal Disease				INTERVAL BETWEEN ONSET AND DEATH 3 days. 5 years 4 1/2 X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None.				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)		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 Sept 1, 1950 , to Sept 27, 1950 , that I last saw the deceased alive on Sept 26, 1950 , and that death occurred at 9:35 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J Newton Wallerstein M.D.				23b. ADDRESS Springfield, Mo		23c. DATE SIGNED 9-27-50.	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9/30/50		24c. NAME OF CEMETERY OR CREMATORY EAST LAWN CEMETERY		24d. LOCATION (City, town, or county) (State) SPRINGFIELD MO.	
DATE REC'D BY LOCAL REG. 9-29-50		REGISTRAR'S SIGNATURE W E Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Jewell Clingner & Co. Springfield, Mo			

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

NOV 6 1950

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 *Ogle Stone Jr*

Licensed Embalmer No. *4126*

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.