

FILED OCT 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33293

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

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5463</u>		Registrar's No. <u>884</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL 2nd JACKSON</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL 2nd JACKSON</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 MI. N. OF STRAFFORD, MO.</u>				d. STREET ADDRESS (If rural, give location) <u>4 MI. N. OF STRAFFORD, MO.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>H.</u> c. (Last) <u>TODD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 8 1950</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>24 APRIL 1866</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ 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 <u>AGRICULTURE</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JACOB TODD</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET ROCK</u>		14. NAME OF HUSBAND OR WIFE <u>ELIZA A. TODD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ELIZA A. TODD RT. 2 STRAFFORD, MO.</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
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) (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 <u>1948</u> , to <u>Oct 8</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>50</u> , and that death occurred at <u>11:15 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Deceased or title) <u>Max Fitch M.D.</u>			23b. ADDRESS <u>Springfield Mo</u>		23c. DATE SIGNED <u>10-9-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10-10-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MULLINAX CEME.</u>		24d. LOCATION (City, town, or county) (State) <u>NEAR STRAFFORD MO.</u>		
DATE REC'D BY LOCAL REG. <u>10-10-50</u>		REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. Klingner & Co. Springfield, Mo.</u>			

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 _____

working under my personal supervision. _____ Student Embalmer No. _____

Signed.....
Student Embalmer

Signed *Max F. [Signature]*

Licensed Embalmer No. *24071*

P. O. Address *[Signature]*

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.