

FILED OCT 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35867

324/90

REG. DIST. NO. 199 PRIMARY REG. DIST. NO. 6086 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural, Salt Fork township) 47 years		c. LENGTH OF OR TOWN Rural, Salt Fork township 0970	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7 miles S.E. Marshall, Mo.		d. STREET ADDRESS (If rural, give location) 7 miles S.E. Marshall, Mo.	
3. NAME OF DECEASED a. (First) Ethel b. (Middle) Mae c. (Last) Steel			4. DATE OF DEATH (Month) (Day) (Year) Oct. 6th, 1950
5. SEX female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 18th, 1883
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	11. BIRTHPLACE (State or foreign country) Pettis County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jiles H. Callis	
13b. MOTHER'S MAIDEN NAME Jennie Adams		14. NAME OF HUSBAND OR WIFE Elias Lester Steel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Elias L. Steel, Marshall, Route # I.		ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Pneumonia (Hypersthenic) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Arterial 42 yrs DUE TO (a) 42 yrs II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture 2 Hips 42 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 7220 F		22. I hereby certify that I attended the deceased from July 1, 1949, to July 6, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 5:40 P.M., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS Marshall, Mo.	
23c. DATE SIGNED Oct. 8-50		24a. BURIAL REMOVAL (Specify) Burial	
24b. DATE Oct. 8th, 1950		24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cem. Marshall, Missouri	
24d. LOCATION (City, town, or county) (State) Marshall, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CAMPBELL-LEWIS-MARSHALL-MO.	
DATE REC'D BY LOCAL REG. Oct 8-1950		REGISTRAR'S SIGNATURE Sidney J. Gray 385	

(Licensed Emballer's Statement on Reverse Side)

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

0970

RECEIVED 10-16-50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 10-16-50

NOV 10 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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

James H. Lewis

Signed
Student Embalmer

Licensed Embalmer No. *7209*

P. O. Address *Marshall 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.