

FILED NOV 20 1950

STANDARD CERTIFICATE OF DEATH

DI. Turner 36750 State File No.

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1006

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Laclede (1530)	
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 Falcon /	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hosp.		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Chloe	b. (Middle) M.	c. (Last) Southard	4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Falcon, Missouri /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Nelson	13b. MOTHER'S MAIDEN NAME Casey	14. NAME OF HUSBAND OR WIFE X
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Vivian H. Southard	ADDRESS Falcon, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 days 4200
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction acute ANTECEDENT CAUSES due to (b) bacterial meningitis heart disease with coronary thrombosis DUE TO (c) thrombosis		
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 checked="" type="checkbox"/> NO <input 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 WORK <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 **4/29, 1950**, to **11/14, 1950**, that I last saw the deceased alive on **11/14, 1950**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Blenn O. T. Wier, M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 11/15/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/16/50	24c. NAME OF CEMETERY OR CREMATORY Lebanon Cemetery	24d. LOCATION (City, town, or county) (State) Lebanon, Mo.
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DATE REC'D BY LOCAL REG. 11-15-50	REGISTRAR'S SIGNATURE W E Handley M.D.	25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 22 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 William Greer

Licensed Embalmer No. 4733

P. O. Address Springfield, 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.