

FILED JAN 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39761**

BIRTH NO. _____ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 4024 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Barry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cassville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cassville 0 05 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Isaac	b. (Middle) Robert	c. (Last) Petty	4. DATE OF DEATH (Month) (Day) (Year) 12-16-1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 4-25-1882	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Barry County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Caleb Petty	13b. MOTHER'S MAIDEN NAME Ammanda Sisney	14. NAME OF HUSBAND OR WIFE Josie Petty
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Loyd Davis-Cassville, 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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic arthritis & Colitis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Bronchitis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			725X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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 Dec 1, 1947, to Dec, 1950, that I last saw the deceased alive on Dec 15, 1950, and that death occurred at 6 2 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Stenn M. Salzer M.D.	23b. ADDRESS Cassville Mo	23c. DATE SIGNED Dec-19
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-20-1950	24c. NAME OF CEMETERY OR CREMATORY Mineral Springs	24d. LOCATION (City, town, or county) (State) Barry County, Missouri
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DATE REC'D BY LOCAL REG. Dec 28-1950	REGISTRAR'S SIGNATURE Grace Williams	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stenn M. Williams Cassville Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED JAN 3 1951

Dist. File 187-35

Date Filed 1-4-51

NOV 3 1961

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 Alex D Williams

Licensed Embalmer No. 4651

P. O. Address Cassville 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.