

FILED APR 30 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12223

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **272**

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

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Oregon</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>	c. LENGTH OF STAY (in this place) <b>2 days</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Couch</b> <b>0950</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>OSZARK OSTEOPATHIC HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>1</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sara Elizabeth</b>	b. (Middle) <b>Cousins</b>	c. (Last) <b>Cousins</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 26, 1951</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11-29-1880</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>James Wesley Carter</b>	13b. MOTHER'S MAIDEN NAME <b>Kathryn Dunn</b>	14. NAME OF HUSBAND OR WIFE <b>Daniel Cousins</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Edna Coffey, Aldrich, Mo.</b>	ADDRESS <b></b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Peritonitis</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Strangulated Hernia</b>		
	DUE TO (c) <b></b>		
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 type="checkbox"/> NO <input checked="" 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) <b>5615</b>
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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?
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22. I hereby certify that I attended the deceased from **4-24-51, 19**, to **4-26-51, 19**, that I last saw the deceased alive on **4-26-51, 19**, and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Miriam A. Stetzel</b> (Degree or title)	23b. ADDRESS <b>700 E. Sunshine, Springfield</b>	23c. DATE SIGNED <b>4/26/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>4/29/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Clear View Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Pokahontas Arkansas</b>
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DATE REC'D BY LOCAL REG. <b>4/27/51</b>	REGISTRAR'S SIGNATURE <b>W E Handley m</b>	25. FEDERAL DIRECTOR'S SIGNATURE <b>Herman Lohmeyer</b> Springfield, Mo.
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MAY 19 1951

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 *Paul Lohmeyer*

Licensed Embalmer No. *4734*

P. O. Address *Spfld, Ma.*

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.