.S. No. 300
Rev. 10-48

FILED APR 30 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12350

BIRTH NO. _____ REG. DIST. NO. 70 PRIMARY REG. DIST. NO. 4124 Registrar's No. 30

0230
4

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

1. PLACE OF DEATH
a. COUNTY Clark
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kahoka
c. LENGTH OF STAY (in this place) 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Webb Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wayland 0230
d. STREET ADDRESS (If rural, give location) 0

3. NAME OF DECEASED (Type or Print) a. (First) Dolly b. (Middle) May c. (Last) Flowers

4. DATE OF DEATH (Month) April (Day) 15 (Year) 1952

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Jan. 19, 1888
9. AGE (In years last birthday) 64 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) Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Wayland, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charles Maloy
13b. MOTHER'S MAIDEN NAME Amelia Egley
14. NAME OF HUSBAND OR WIFE Allen E. Flowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mr. Allen E. Flowers ADDRESS Wayland

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage

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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 331X
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5, 1951, *to* 4-15, 1952, *that I last saw the deceased alive on* 4-15, 1952, *and that death occurred at* 3-50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] D.O.
23b. ADDRESS Kahoka Mo
23c. DATE SIGNED 4-16 52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11
24b. DATE April 19 1952
24c. NAME OF CEMETERY OR CREMATORY Frazee Cemetery
24d. LOCATION (City, town, or county) (State) Wayland Mo.

DATE REC'D BY LOCAL REG. 4/22-52
REGISTRAR'S SIGNATURE [signature] 61
25. FUNERAL DIRECTOR'S SIGNATURE Tutting Und. ADDRESS Kahoka

(Licensed Embalmer's Statement on Reverse Side)

MAY 2 1952

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 Otis L. Sutting

Licensed Embalmer No. 2965

P. O. Address Luray 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.