

STANDARD CERTIFICATE OF DEATH

Dr. Hagedorn
State File No. **9150**

FILED APR 2 1953

BIRTH NO. _____ REG. DIST. NO. **69** PRIMARY REG. DIST. NO. **4122** Registrar's No. **5**

1. PLACE OF DEATH a. COUNTY CHRISTIAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY OR TOWN RURAL ROUTE #1 NIXA		c. CITY OR TOWN RURAL ROUTE #1, NIXA 0390	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Rt. #1, NIXA, MO.	
d. FULL NAME OF HOSPITAL OR INSTITUTION RT. #1, NIXA, MO.			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) GERTRUDE	b. (Middle) CECILIA	c. (Last) WASSON	MARCH 22, 1953		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT. 15, 1891	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) 9	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME HENRY VIENHAGE		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE PAUL E. WASSON	
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. ?		17. INFORMANT'S SIGNATURE OR NAME ADDRESS PAUL E. WASSON, RT. #1, NIXA, MO.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 year	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma Breast			
		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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma Breast 170x		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Feb 17, 1953** to **Mar 23, 1953**, that I last saw the deceased alive on **Mar 15, 1953**, and that death occurred at **7:20 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE Glenn C. Hoover M.D. (Degree or title)		23b. ADDRESS 609 Cherry Springfield Mo		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/24/53		24c. NAME OF CEMETERY OR CREMATORY GLENN CEMETERY	
				24d. LOCATION (City, town, or county) (State) SO. OF NIXA MISSOURI	

DATE REC'D BY LOCAL REG. 3-24-53		REGISTRAR'S SIGNATURE Allene Greer		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. H. BOHMEYER, SPRINGFIELD, MO.	
---	--	---	--	--	--

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

No. 300
10-48

220
1

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 Luvin T. Swadley

Licensed Embalmer No. 4814

P. O. Address Springfield

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.