

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9403

State File No. _____

FILED APR 6 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 335

396
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
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 Springfield, RURAL	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Springfield RFD#4	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) ARLIA	b. (Middle) G.	c. (Last) CONLEY	4. DATE OF DEATH (Month) (Day) (Year) March 30 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 31 Jan. 1889	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 15 MIN. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY In home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME Tom Choate	13b. MOTHER'S MAIDEN NAME Rebecca Bryan	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or date of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs. S.S. Hubbell	ADDRESS Springfield, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial asthma	DUE TO (b) _____		
ANTECEDENT CAUSES	DUE TO (c) 241x		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis		

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)
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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 Feb, 1953, to March 30, 1953 that I last saw the deceased alive on March 29, 1953, and that death occurred at 5:00Am., from the causes and on the date stated above.

23a. SIGNATURE D. Dean Cunningham, M.D. (Degree or title)	23b. ADDRESS 1715 Booneville	23c. DATE SIGNED 3-30-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 1, 1953	24c. NAME OF CEMETERY OR CREMATORY Brighton Cemetery	24d. LOCATION (City, town, or county) (State) Brighton Mo.
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DATE REC'D BY LOCAL REG. 3-31-53	REGISTRAR'S SIGNATURE Edith Williams Registrar	25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO.	ADDRESS Springfield, Mo.
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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.....

Ogle Stone Jr.

Licensed Embalmer No.

4176

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.