

FILED JUN 15 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17649

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>534</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Springfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>1004 St. Louis</u> <u>0396</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>INA</u> b. (Middle) _____ c. (Last) <u>BLACK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 5 1953</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11 March 1884</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Benjamin Andrews</u>		13b. MOTHER'S MAIDEN NAME <u>Harriet Paulson</u>		14. NAME OF HUSBAND OR WIFE <u>Baxter O. Black</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-05-3582</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Baxter Black (Husband) Springfield, Mo</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Rectum (Squamous cell)</u> 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. <u>154X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
19a. DATE OF OPERATION <u>9-15-52</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinomatosis involving Abdomen</u>					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) _____ m.		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 <u>7-31, 1952</u> , to <u>6-5-1953</u> , that I last saw the deceased alive on <u>6-5-1953</u> , and that death occurred at <u>10:55 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Clayton J. Hoover M.D.</u>				23b. ADDRESS <u>609 Cherry St Springfield</u>		23c. DATE SIGNED <u>6-8-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-7-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield Mo.</u>		
DATE REC'D BY LOCAL REG. <u>6-8-53</u>		REGISTRAR'S SIGNATURE <u>Carroll Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. KLINGNER & CO. Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....
Signature of Student Embalmer

Signed *Ogle Stone Jr.*.....

Licensed Embalmer No. *417*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.