

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3929**

BIRTH NO. **FILED FEB 23 1954** REG. DIST. NO. **27** PRIMARY REG. DIST. NO. **3005** Registrar's No. **16**

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

1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Bates	
b. CITY OR TOWN Butler	c. LENGTH OF STAY (in this place) 15 Da	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Mound Twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Butler Memorial Hosp.		d. STREET ADDRESS (If rural, give location) 0070	

3. NAME OF DECEASED (Type or Print)	a. (First) Laura	b. (Middle) Ethel	c. (Last) Ewing	4. DATE OF DEATH (Month) (Day) (Year) Feb. 16, 1954
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5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) m	8. DATE OF BIRTH March 18, 1886	9. AGE (In years) (Months) (Days) (Hours) (Min.) 67 10 28
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwfe	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Albany Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Joel General Ragan	13b. MOTHER'S MAIDEN NAME Nancy Brannon	14. NAME OF HUSBAND OR WIFE Charles Floyd Ewing
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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 C.F. Ewing, Adrian Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia Lobar		
	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. Tuberculosis, heart			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 490 x	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 **Jan 30, 1954, to Feb 15, 1954**, that I last saw the deceased alive on **Feb 15, 1954**, and that death occurred at **4:50 PM**, from the causes and on the date stated above.

23a. SIGNATURE E.E. Robinson M.D.	(Degree or title)	23b. ADDRESS Adrian Mo.	23c. DATE SIGNED Feb 16-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-18-54	24c. NAME OF CEMETERY OR CREMATORY Crescent Hill Cem.	24d. LOCATION (City, town, or county) (State) Adrian Mo.
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DATE REC'D BY LOCAL REG. Feb. 17-54	REGISTRAR'S SIGNATURE Randall Kerney 17-6	25. FUNERAL DIRECTOR'S SIGNATURE Sy Funeral Service	ADDRESS Adrian Mo
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(Licensed Embalmer's Statement on Reverse Side)

MAR 8 1951
FEB 24 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *[Signature]*

Signed.....
Student Embalmer

Licensed Embalmer No. *3650*

P. O. Address *Adrian 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.