

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. FITCH
State File No. **8241**

BIRTH NO. FILED **APR 5 1954** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **316**

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) SPRINGFIELD		c. CITY - OR TOWN SPRINGFIELD	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 422 S. MAIN	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSF.			

3. NAME OF DECEASED (Type or Print)	a. (First) EMOGENE	b. (Middle)	c. (Last) AVERO	4. DATE OF DEATH (Month) (Day) (Year) MARCH 26 1954
-------------------------------------	---------------------------	-------------	------------------------	---

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH November 22, 1915	9. AGE (in years last birthday) 38	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
----------------------	-------------------------------	---	---	---	-----------------------------------	---------------------------------

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 (City and State or Foreign Country) Newton Co. Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	--

13a. FATHER'S NAME Robert E. White	13b. MOTHER'S MAIDEN NAME Elizabeth Shelly	14. NAME OF HUSBAND OR WIFE -----
--	--	---

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. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert E. White, Granby, Missouri
---	---	---

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 2 hr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sub-Arachnoid Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Retinal Hypertension		
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 330X	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I hereby certify that I attended the deceased from **June 1942**, to **3-26**, 19**54** that I last saw the deceased alive on **3-26**, 19**54**, and that death occurred at **11 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Thos. H. Lohmeyer	(Degree or title) M.D.	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 3-27-54
--	-------------------------------	---------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial	24b. DATE 3/29/54	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) Granby, Missouri
--	-----------------------------	--	--

DATE REC'D BY LOCAL REG. 3/29/54	REGISTRAR'S SIGNATURE Carroll Williamson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. H. LOHMEYER SPRINGFIELD, MO.
--	--	--

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

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 *Lucas S. Swally*.....

Licensed Embalmer No. 388

P. O. Address SPRINGFIELD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.