

FILED APR 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14725

372

4545

Registrar's No. 17

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Webster</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshfield Mo</u>		c. LENGTH OF STAY (In this place) <u>39 years</u>		c. CITY OR TOWN <u>Marshfield</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 _____				e. STREET ADDRESS (If rural, give location) <u>1128</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bertha</u> b. (Middle) <u>I</u> c. (Last) <u>ATKINSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 15, 1954</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>Oct 8 1884</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Webster County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>G.W. Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Owen</u>		14. NAME OF HUSBAND OR WIFE <u>Floyd ATKINSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Floyd ATKINSON Marshfield 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral Pyelo-Nephritis</u> ANTECEDENT CAUSES DUE TO (b) <u>with anemia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Good</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 <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>4/18</u> , 19 <u>54</u> , to <u>4/13</u> , 19 <u>54</u> that I last saw the deceased alive on <u>4/13</u> , 19 <u>54</u> , and that death occurred at <u>6:30 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>G. P. H. French M.D.</u>				23b. ADDRESS <u>Shannon Mo.</u>		23c. DATE SIGNED <u>4/19/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-18-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Marshfield Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Marshfield Mo</u>	
DATE REC'D. BY LOCAL REG. <u>4-21-54</u>		REGISTRAR'S SIGNATURE <u>J. Francis 3922</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Barber-Barro</u>		ADDRESS <u>Marshfield Mo</u>	

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 *Wm. S. Williams*.....

Licensed Embalmer No. *465*.....

P. O. Address... *Marshfield*.....

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.