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

FILED DEC 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36915

State File No.

BIRTH NO. REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4154 Registrar's No. 54-98

1. PLACE OF DEATH
a. COUNTY Dade
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greenfield
c. LENGTH OF STAY (in this place) 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 217 McPherson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Dade
c. CITY OR TOWN Greenfield
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
STREET ADDRESS (If rural, give location) 217 McPherson 0240

3. NAME OF DECEASED (Type or Print)
a. (First) Irene
b. (Middle) —
c. (Last) O'Brien

4. DATE OF DEATH (Month) (Day) (Year) Dec. 1, 1954

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Jan 4, 1869
9. AGE (In years last birthday) 85 | 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) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and State or Foreign Country) Menurva, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Huett
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE L. C. O'Brien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. N.V. Plasmyer; Greenfield, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 334X
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1, 1954, *to* 12-1, 1954, *that I last saw the deceased alive on* 12-1, 1954, *and that death occurred at* 12:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE W. O. Cauman (Degree or title) MD
23b. ADDRESS Greenfield, Mo.
23c. DATE SIGNED 12-2-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 3, 1954
24c. NAME OF CEMETERY OR CREMATORY Greenfield Cem.
24d. LOCATION (City, town, or county) (State) Greenfield, Mo.

DATE REC'D BY LOCAL REG. 12-2-54
REGISTRAR'S SIGNATURE J. C. Canada 478
25. FUNERAL DIRECTOR'S SIGNATURE J. C. Canada
ADDRESS Greenfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, ~~or by~~ ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed J. C. Canada

Licensed Embalmer No. 419

P. O. Address Greenfield,

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