

FILED FEB 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4546

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 151

| | | | |
|---|--|--|------------------------------------|
| 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 town) Springfield | | c. LENGTH OF STAY (in this place) 6 Days | c. CITY OR TOWN Springfield |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| STREET ADDRESS 438 E. Harrison | | (If rural, give location) 03960 | |

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|-------------------------------------|-------------------------|------------------------|---------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) EDITH | b. (Middle) RAY | c. (Last) THOMPSON | 4. DATE OF DEATH (Month) (Day) (Year) February 14, 1955 |
|-------------------------------------|-------------------------|------------------------|---------------------------|--|

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|----------------------|-------------------------------|---|---------------------------------------|---|---|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 27 March 1888 | 9. AGE (In years last birthday) 66 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 2 HRS. Hours 0 Min. 0 |
|----------------------|-------------------------------|---|---------------------------------------|---|---|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY In Home | 11. BIRTHPLACE (City and State or Foreign Country) Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME XXXX Oscar XX Ray | 13b. MOTHER'S MAIDEN NAME Emily J. Morris | 14. NAME OF HUSBAND OR WIFE Deceased |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. No | 17. INFORMANT'S SIGNATURE OR NAME Medical Records | 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, ashenia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy | | INTERVAL BETWEEN ONSET AND DEATH 5 days Yes |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 334X | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from Sept, 1953, to Feb. 14, 1955, that I last saw the deceased alive on Feb. 14, 1955 and that death occurred at 9:20A m., from the causes and on the date stated above.

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|-----------------------------------|---------------------------------|--|---------------------------------|
| 23a. SIGNATURE [Signature] | (Degree or title) Om. D. | 23b. ADDRESS Medical Arts Bldg. Springfield, Missouri | 23c. DATE SIGNED 2-15-55 |
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|---|--------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 2-16-55 | 24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | 24d. LOCATION (City, town, or county) (State) Springfield, Missouri |
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| DATE REC'D BY LOCAL REG. 2-17-55 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] | ADDRESS Co. Springfield, Mo |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 24 1956

APR 5 1956

APR 5 1956

MAR 2 1956

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 *Mal Rode*.....
Licensed Embalmer No. *40*.....
P. O. Address *Permy*.....

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.