

FILED NOV 3 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34475**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **314** PRIMARY REG. DIST. NO. **4459** Registrar's No. **57**

1. PLACE OF DEATH a. COUNTY <b>St. Clair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Osceola</b>		c. CITY OR TOWN <b>Lowry City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>6 weeks</b>		• STREET ADDRESS (If rural, give location) <b>0400</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Todd's Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Elizabeth</b>	b. (Middle) <b>Ellen</b>	c. (Last) <b>Bunch</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct; 25, 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 26, 1873</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Henry County Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Alsolom Johnson</b>	13b. MOTHER'S MAIDEN NAME <b>Rosa Bell Rainey</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>George Bunch, Lowry City Mo.</b>	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic Pneumonia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hip Fracture 6/18/55</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>9040</b>

19a. DATE OF OPERATION <b>6/21/55</b>	19b. MAJOR FINDINGS OF OPERATION <b>Fracture of Hip</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) <b>SOICIDE</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. (CITY, TOWN, OR TOWNSHIP) <b>Lowry City</b> (COUNTY) <b>St. Clair</b> (STATE) <b>Miss.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 18 1955 A</b>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>Fall</b>
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22. I hereby certify that I attended the deceased from **Oct 25, 1955**, to **Oct 25, 1955**, that I last saw the deceased alive on **Oct 25, 1955**, and that death occurred at **4 P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b> (Degree or title)	23b. ADDRESS <b>Lowry City, Mo.</b>	23c. DATE SIGNED <b>10/26/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10-27-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lowry City</b>	24d. LOCATION (City, town, or county) (State) <b>Lowry City Mo.</b>
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DATE REC'D BY LOCAL REG. <b>10-26-55</b>	REGISTRAR'S SIGNATURE <b>Ruth Seewers</b> <b>288-C</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Goodrich - Osceola, Mo.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *J. B. [unclear]*.....

Licensed Embalmer No. *3020*.....

P. O. Address *Pease*.....

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.