

FILED NOV 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37160

State File No.

BIRTH NO.		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>5368</u>		Registrar's No. <u>464</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>DeFayette</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Blue</u>		c. LENGTH OF STAY (If in place) <u>2 yrs.</u>		c. CITY OR TOWN <u>Odessa</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 <u>Mace Nursing Home</u> <u>24 Highway & Mays Rd.</u>				e. STREET ADDRESS (If rural, give location) <u>05401</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ethel</u>			b. (Middle) <u>D.</u>		c. (Last) <u>Felts</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22, 1955</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 22, 1877</u>		9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U</u>			
13a. FATHER'S NAME <u>Not Known</u>			13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>L.V. Dawson, Excelsior Springs.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>General arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4201</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>2 yrs about</u> <u>3 years</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>No operation</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)		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 <u>Nov 17, 1954</u> , to <u>Nov 22, 1955</u> , that I last saw the deceased alive on <u>Nov 17, 1955</u> , and that death occurred at <u>2:15 Pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>E. H. Allen M.D.</u>				23b. ADDRESS <u>Independence, Mo</u>		23c. DATE SIGNED <u>Nov 22, 1955</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 25, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Odessa, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>11-25-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Odessa, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 26 1963

SEP 4 1963

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 *James F. [Signature]*.....

Licensed Embalmer No. *150*.....

P. O. Address *Albany*.....

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.