

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED FEB 14 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 133

1. PLACE OF DEATH a. COUNTY <u>Green</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	c. LENGTH OF STAY (in this place) <u>1 day</u>	c. CITY OR TOWN <u>Monett</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>R/2 S-E Monett Mo 65051</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u> b. (Middle) <u>Simonson</u> c. (Last) <u>Simonson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 8 56</u>		
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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>3-29-1881</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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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 <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>State of Washington</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>John Young</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth (UNKNOWN)</u>	14. NAME OF HUSBAND OR WIFE <u>Charley Simonson</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Chas. Simonson - Monett Mo.</u>
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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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of sigmoid colon</u>	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>signifed</u> DUE TO (c) <u>Intestinal</u>		<u>1 yr</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			

19a. DATE OF OPERATION <u>2/7/56</u>	19b. MAJOR FINDINGS OF OPERATION <u>Jaune obstruction 153X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., to 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?
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22. I hereby certify that I attended the deceased from 2/7, 1956 to 2/8, 1956, that I last saw the deceased alive on 2/8, 1956 and that death occurred at 10 AM on 2/8, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Chas E Lockhart MD</u>	23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>2/10/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal to Burial</u>	24b. DATE <u>2-8-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cassville</u>	24d. LOCATION (City, town, or county) (State) <u>Mo</u>
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DATE REC'D BY LOCAL REG. <u>2-10-56</u>	REGISTRAR'S SIGNATURE <u>Edith Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Doyle Williams Cassville, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Arly E. Williamson*

Licensed Embalmer No. *488*

P. O. Address *Casville*

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.