

FILED FEB 20 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5700

BIRTH NO. _____ REG. DIST. NO. 234 PRIMARY REG. DIST. NO. 5812 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY MORGAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MORGAN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL HAWCREEK		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL HAWCREEK 0710	
c. LENGTH OF STAY (In this place) 4 yrs		d. STREET ADDRESS (If rural, give location) 5 MILES WEST OF STOVER	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5 MILES WEST OF STOVER			

3. NAME OF DECEASED (Type or Print) a. (First) ETTA	b. (Middle) MAY	c. (Last) DORITY	4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 13 1956
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 17 1892	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 5 Days 26	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) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) CAMDENTON MO.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME WILLIAM RAYL	13b. MOTHER'S MAIDEN NAME DELIA LUY	14. NAME OF HUSBAND OR WIFE S.H. DORITY
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME S.H. DORITY	ADDRESS STOVER MO.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH ONE DAY
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral bronchopneumonia		
	ANTECEDENT CAUSES DUE TO (b) Cerebrovascular accident DUE TO (c) Hypertension, Malignant		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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., 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)	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 1953, 1953, to 2-13, 1956, that I last saw the deceased alive on 2-11, 1956, and that death occurred at 1:15 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ray Lyle, M.D.	23b. ADDRESS Versailles, Mo.	23c. DATE SIGNED 2-18-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 15 1956	24c. NAME OF CEMETERY OR CREMATORY DORITY CEMETERY	24d. LOCATION (City, town, or county) (State) CAMDEN COUNTY MO
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DATE REC'D BY LOCAL REG. 2-18-1956	REGISTRAR'S SIGNATURE Wm L. Ripberger	25. FUNERAL DIRECTOR'S SIGNATURE F. L. Stevenson	ADDRESS Stover Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

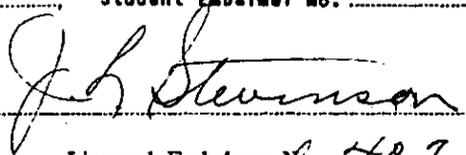
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....



Licensed Embalmer No. 4073

P. O. Address Stoner Mo

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 this body is not embalmed, fact should be so stated above.