Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-047203

STATE FILE NUMBER

FILED FEB 10 1958 Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 2

1. PLACE OF DEATH
a. COUNTY: Newton
b. CITY OR TOWN: Stella — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Cardwell Hosp — Length of stay in 1b: 1 Week

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Newton
c. CITY OR TOWN: Neosho 0730 — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): Route # 4 — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Bertha Middle: Last: Capps
4. DATE OF DEATH: Month: Dec Day: 28 Year: 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan 9, 1891
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (City and state or country): Ritchey, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: W.B. York
13b. MOTHER'S MAIDEN NAME: Lucindia Meadow
14. NAME OF HUSBAND OR WIFE: W.A. Capps
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: W.A. Capps Address: Neosho, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Medullary Failure — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Anoxia — 2 HR.
DUE TO (c) Post-Operative Hypotension — 4HR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized abdominal carcinomatosis 1992
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-19-1958, to 12-28-1958 and last saw her alive on 12-27-1958
Death occurred at 12:24 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C.R. Johnson (Degree or title): D.O.
22b. ADDRESS: Stella, Missouri
22c. DATE SIGNED: 1-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Dec 29, 1958
23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery
23d. LOCATION (City, town, or county) (State): Newtonia, Mo.

24. FUNERAL DIRECTOR: Clark Funeral Home ADDRESS: Neosho, Mo.
25. DATE RECD. BY LOCAL REG.: 1-16-59
26. REGISTRAR'S SIGNATURE: Mildred Moberly

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

District File Number 259-23

Date Filed FEB 9 1959

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 Fred L. Clark

Licensed Embalmer No. 5056

P. O. Address 312 So. Wood Neosho, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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