

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018892
STATE FILE NUMBER
2 4748
Registrar's

FILED JUN 1 1959 Registration District No. Primary Registration District No. Registrar's

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW MEXICO</u> b. COUNTY <u>Green</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ARTESIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Firmen Desloge</u>		Length of stay in 1b <u>30 d.</u>	d. STREET ADDRESS (If outside, give location) <u>102 W. Chisum</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ola</u> Middle <u>Emily</u> Last <u>Alcorn</u>			4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>'59</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1895</u>	9. AGE (In years last birthday) <u>64</u>	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) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <u>Fremont, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Oliver J. Warner</u>		13b. MOTHER'S MAIDEN NAME <u>Manerva Holland</u>		14. NAME OF HUSBAND OR WIFE <u>H. J. Alcorn</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.	17. INFORMANT <u>Vena Hall (sister)</u> Address <u>4320 Maryland Ave</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism (massive)</u> <u>thrombosis of left leg</u> DUE TO (b) <u>Thrombosis of Leg Veins</u> DUE TO (c) <u>Leg Veins</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>??</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of cervix</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 <u>4-26-59</u> to <u>5-14-59</u> and last saw her alive on <u>5-14-59</u> Death occurred at <u>5-14-59 12:25 Pm at the home stated above</u> ; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ralph C. Schwarz</u> (Type or print) <u>Ralph C. Schwarz</u> M.D.			22b. ADDRESS <u>9141 No. Swan Dr.</u> <u>9141 NORTH SWAN CR.</u>		22c. DATE SIGNED <u>5/14/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) (State) <u>Artesia, New Mexico.</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington, Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 15 59</u>		26. REGISTRAR'S SIGNATURE <u>Ralph Smith, M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

VS SEP 20 1960

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 *Lawrence O. Gerling*

Licensed Embalmer No. *4979*

P. O. Address *St. Louis, 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.