

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24453**
Registrar's No. **713**

FILED AUG 7 - 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. LENGTH OF STAY (In this place) 5 yr.		d. STREET ADDRESS (If rural, give location) 1101 N. SHERMAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1101 N. SHERMAN			

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) ELLEN	c. (Last) MARLEY	4. DATE OF DEATH (Month) (Day) (Year) Aug 1 1953
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5. SEX FEMALE	6. COLOR OR RACE 3 NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH MAY 6 1869	9. AGE (In years / last birthday) 84	if UNDER 1 YEAR: Months 2	if UNDER 1 MRS. Hours 7
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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 _____	11. BIRTHPLACE (State or foreign country) MT. PLEASANT IOWA	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George W. Kelley	13b. MOTHER'S MAIDEN NAME Rachel Weaver	14. NAME OF HUSBAND OR WIFE DECEASED
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Blanch Duffie	ADDRESS 3136 N. NATIONAL
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Insufficiency		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Asorbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? 4222 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 **July 10, 1953**, to **Aug 1, 1953**, that I last saw the deceased alive on **Aug 1, 1953**, and that death occurred at **6 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Luman W. Brown M.D.	(Degree or title) _____	23b. ADDRESS 307 1/2 College Springfield Mo	23c. DATE SIGNED 8/1/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-4-53	24c. NAME OF CEMETERY OR CREMATORY Ozark	24d. LOCATION (City, town, or county) (State) Ozark Mo.
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DATE REC'D BY LOCAL REG. 8-3-53	REGISTRAR'S SIGNATURE Ernest Williamson	25. FUNERAL DIRECTOR'S SIGNATURE W.P. Campbell	ADDRESS 825 Washington
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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 W. R. Campbell

Licensed Embalmer No. 1747

P. O. Address Springfield

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.