

STANDARD CERTIFICATE OF DEATH

State File No. **41886**

FILED DEC 23 1952

REG. DIST. NO.

PRIMARY REG. DIST. NO. **4158**Registrar's No. **68**

0300

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY DALLAS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, write RURAL and give township) BUFFALO		c. CITY (If outside corporate limits, write RURAL and give township) Buffalo 0300	
c. LENGTH OF STAY (In this place) 10 yrs		d. STREET ADDRESS (If rural, give location) D	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) FLORA b. (Middle) ADELINE c. (Last) McARRON			4. DATE OF DEATH (Month) (Day) (Year) 12-13-1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-29-1883
9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 1 Days 14	IF UNDER 24 HRS. Hours 1 Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Laclede Co Mo
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Winder Bladsoe	
13b. MOTHER'S MAIDEN NAME Elizabeth Goble		14. NAME OF HUSBAND OR WIFE Ray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Ray McArron ADDRESS Buffalo Mo			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 day ANTECEDENT CAUSES DUE TO (b) Cerebral Hemorrhage 4 day DUE TO (c) Hypertension + arteriosclerosis 10 yrs + 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 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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)			
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			
22. I hereby certify that I attended the deceased from May , 19 48 , to 12-13 , 19 52 , that I last saw the deceased alive on 12-13 , 19 52 , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE O. Griffin (Degree or title) MO		23b. ADDRESS Buffalo Mo	
23c. DATE SIGNED 12-16-52			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-16-1952	
24c. NAME OF CEMETERY OR CREMATORY Oak Lawn		24d. LOCATION (City, town, or county) (State) Buffalo Mo	
DATE REC'D BY LOCAL REG. 12-17-52		REGISTRAR'S SIGNATURE Ernest P. Smith	
25. FUNERAL DIRECTOR'S SIGNATURE R. B. Jones		ADDRESS Buffalo Mo	

1954
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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.

Signed..... *Marion B Jones*

Signed.....
Student Embalmer

Licensed Embalmer No. *4322*

P. O. Address *Buffalo, 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.