

FILED JUN 29 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20755**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **211**

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

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) Harrisburg		c. CITY (If outside corporate limits, write RURAL and give township) Harrisburg 0644	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 604 S. Haydon St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lexington Hospital			
3. NAME OF DECEASED a. (First) Mary		c. (Last) Paxton	
b. (Middle) B.		4. DATE OF DEATH (Month) (Day) (Year) June 18, 51	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 21, 1892
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 5	IF UNDER 4 HRS. Hours 5 Min.
10a. 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) Germantown, Ill
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Franklin Steaps		13b. MOTHER'S MAIDEN NAME Eugenia Mischoer	
14. NAME OF HUSBAND OR WIFE John			
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.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Elmer Meyer, 604 S. Haydon		ADDRESS Harrisburg 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) Cystitis + Pyelitis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Nephritis DUE TO (c) Arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 260X	
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 28, 1951 , to June 16, 1951 , that I last saw the deceased alive on June 16, 1951 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. N. Watuschinski M.D.		23b. ADDRESS 508 Broadway Hannibal Mo	
23c. DATE SIGNED 6-18-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-18-51	
24c. NAME OF CEMETERY OR CREMATORY Granovier Burial Park		24d. LOCATION (City, town, or county) (State) Harrisburg Marion MO	
DATE REC'D BY LOCAL REG. 6/19/51		REGISTRAR'S SIGNATURE A. E. M. Lucke Deputy	
FUNERAL DIRECTOR'S SIGNATURE James O'Donnell		ADDRESS Hannibal MO	

RECEIVED JUN 25 1951

ARION CO. HEALTH DEPT.

DATE FILED JUN 27 1951

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 *Michael J. O'Connell*

Licensed Embalmer No. *3246*

P. O. Address *Hennipaw 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.