

FILED DEC 3 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38209

BIRTH NO. _____ REG. DIST. NO. 237 PRIMARY REG. DIST. NO. 4353 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY New Madrid		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gideon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gideon	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) Francis Anna Mary Daugherty			4. DATE OF DEATH (Month) (Day) (Year) 11 27 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept 1 1893	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 2 Days 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Adams Co Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME W.P. Anderson	13b. MOTHER'S MAIDEN NAME Mary Melissa Anderson	14. NAME OF HUSBAND OR WIFE J. Daugherty
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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 William J Daugherty	ADDRESS _____
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 5 min
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion		
	DUE TO (c) Continuum of long-ann back		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20hrs.	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? 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) (Min) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **11-26-51**, to **11-27-51**, that I last saw the deceased alive on **11-26-51**, and that death occurred at **Jesam.**, from the causes and on the date stated above.

23a. SIGNATURE Jos Hopkins, M.D.	23b. ADDRESS Gideon, Mo	23c. DATE SIGNED 11/27/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-29-51	24c. NAME OF CEMETERY OR CREMATORY Belfonte	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
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DATE REC'D BY LOCAL REG. 11-28-51	REGISTRAR'S SIGNATURE Lena Hopkins	25. FUNERAL DIRECTOR'S SIGNATURE Lloyd M. Russell	ADDRESS Piggott, Mo
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By **Tom DeSaba** Embalmer (Statement on Reverse Side)

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

1770

RECEIVED

DEC 1 - 1951

DISTRICT HEALTH OFFICE No. 6

File No.....

MAR 11 1952

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 me

working under my personal supervision.

Student Embalmer No.....

Signed Lloyd M. Russell

Signed.....
Student Embalmer

Licensed Embalmer No. 509 - Ark

P. O. Address Piggott, Ark.

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.