

FILED JUN 26 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23583

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **328** PRIMARY REG. DIST. NO. **3073** Registrar's No. **17**

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)	
a. COUNTY <b>Scott</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Chaffee</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Chaffee</b>	
c. LENGTH OF STAY (In this place) <b>27yr</b>		d. STREET ADDRESS (If rural, give location) <b>111 W. Parker</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>C F Wiedman's Home</b>			

<b>3. NAME OF DECEASED</b>			<b>4. DATE OF DEATH</b>		
a. (First) <b>Frances</b> b. (Middle) <b>Kucille</b> c. (Last) <b>Waldron</b>			Month (Day) (Year) <b>June 15 1953</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>May 9 1897</b>		9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR: Hours   Days   Months   Years   If UNDER 1 HOUR: Hours   Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <b>New Madrid Mo</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>James William Hutton</b>		13b. MOTHER'S MAIDEN NAME <b>Marquet Catherine Tarrington</b>		14. NAME OF HUSBAND OR WIFE <b>William A Waldron</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mr C F Wiedman</b>	
				ADDRESS <b>Chaffee Mo</b>	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*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>		<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>		ANTECEDENT CAUSES		<b>10 MIN</b>	
DUE TO (b) <b>Arteriosclerosis</b>		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death. <b>CARDIOVASCULAR-RENAL DISEASE</b>		<b>34R?</b>	

19a. DATE OF OPERATION <b>NONE</b>		19b. MAJOR FINDINGS OF OPERATION: <b>NONE</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>NATURAL</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>NONE</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>NONE</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>NONE</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>NONE</b>	

22. I hereby certify that I attended the deceased from **6-15**, 1953, to **6-15**, 1953, that I last saw the deceased alive on **6-15**, 1953, and that death occurred at **1:50 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H. J. Mesebach, D.O.</b>		23b. ADDRESS <b>Chaffee, Mo.</b>		23c. DATE SIGNED <b>6-16-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>6-17-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Fairmont</b>	
				24d. LOCATION (City, town, or county) (State) <b>Cape Girardeau Mo</b>	

DATE REC'D BY LOCAL REG. <b>6-18-53</b>		REGISTRAR'S SIGNATURE <b>Miss Paul Bryling</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Bisplinghoff</b>	
				ADDRESS <b>Funeral Home Chaffee Mo</b>	

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

RECEIVED 6-19-53  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 653.139

JUL 1 1953

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 Jack J. Burnett

Licensed Embalmer No. 4472

P. O. Address Chaffee, 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.