

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9193

State File No.

BIRTH FILED APR 12 1954 REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo		b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hillsboro		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Festus	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Cedar Grove Nursing Home		d. STREET ADDRESS (If rural, give location) 0502			

3. NAME OF DECEASED (Type or Print) a. (First) Lena			b. (Middle) —			c. (Last) DuFour			4. DATE OF DEATH (Month) (Day) (Year) Apr. 4, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Mar. 30, 1874		9. AGE (In years last birthday) 80/0/4		IF UNDER 1 YEAR Months Days Hours 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 (City and State or Foreign Country) Prarie DeBoucher Ill /			12. CITIZEN OF WHAT COUNTRY? U.S.A		

13a. FATHER'S NAME Jules M. DuFour			13b. MOTHER'S MAIDEN NAME Rosellie Elliott			14. NAME OF HUSBAND OR WIFE Never married		
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. None			17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. E. O. Price, Crystal City, 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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease, with terminal acute pulmonary edema.						INTERVAL BETWEEN ONSET AND DEATH 6 months	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized and coronary arterio-sclerosis.							
		DUE TO (c) cerebral arteriosclerosis with mental changes.						one year	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 4200	
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 **Sept. 9, 1953, to April 4, 1954**, that I last saw the deceased alive on **April 4, 1954**, and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Thomas A. Donnell M.D.		22b. ADDRESS Sasoto, Mo		22c. DATE SIGNED 4-4-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/5/54		24c. NAME OF CEMETERY OR CREMATORY Catholic		24d. LOCATION (City, town, or county) (State) Festus Mo	
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DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE Kathleen Menden		141-0		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. W. Wray Festus Mo	
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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.

Student

Student Embalmer

Signed _____



Licensed Embalmer No. 3010

P. O. Address Fenton 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.