No. 300
10.48

0941
0

FILED MAY 10 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13081

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 128

1. PLACE OF DEATH
a. COUNTY St Francois
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonne Terre, Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonne Terre Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mayflower, Mo.
d. STREET ADDRESS (If rural, give location) 0620

3. NAME OF DECEASED (Type or Print)
a. (First) Martha b. (Middle) Elizabeth c. (Last) Whitener

4. DATE OF DEATH (Month) (Day) (Year) May 1, 1954

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec. 21 1877
9. AGE (In years last birthday) 76 If under 1 year: Months 4 Days 10 If under 1 hr.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME W. Nathaniel Gentry
13b. MOTHER'S MAIDEN NAME Cantsay
14. NAME OF HUSBAND OR WIFE H. L. Whitener

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME H. L. Whitener **ADDRESS** Mayflower 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

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 4201
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1, *, 1954, to* May 1, *, 1954, that I last saw the deceased alive on* May 1, *, 1954, and that death occurred at* 6:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Jack M. Fuller M.D.
23b. ADDRESS 33 N Allen St.
23c. DATE SIGNED 5/3/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 5/4/54
24c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.
24d. LOCATION (City, town, or county) (State) Straughns Ind.

DATE REC'D BY LOCAL REG. May 3, 1954
REGISTRAR'S SIGNATURE Esther Rudolph
25. FUNERAL DIRECTOR'S SIGNATURE [illegible]
ADDRESS Mayflower Mo

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 26 1954

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 G. J. Claycomb

Licensed Embalmer No. 3706

P. O. Address Bonne Terre 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.