

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6269 State File No. 26104

BIRTH NO. _____ REG. DIST. NO. 573 PRIMARY REG. DIST. NO. 4545 Registrar's No. 30

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

1. PLACE OF DEATH a. COUNTY Webster		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Webster	
b. CITY (If outside corporate limits, write RURAL and give town) Rural Ozark		c. CITY OR TOWN Rural Ozark	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 120
c. LENGTH OF STAY (in this place) 3 months		e. STREET ADDRESS (If rural, give location) Marshfield Rt. #4 Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) Hester		b. (Middle) Page	
c. (Last) Page		4. DATE OF DEATH (Month) (Day) (Year) June 26 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH March 17 1860
9. AGE (In years last birthday) 94	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Osceola Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John F Wells	13b. MOTHER'S MAIDEN NAME Catherine Long	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME M.L. Barnard ADDRESS New Virginia Iowa	
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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Decompensated Hypertensive Heart Disease. DUE TO (c) Arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH
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 443 X		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6-1-1948 to 6-26-1954 , that I last saw the deceased alive on 6-26-1954 , and that death occurred at 12 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title) 2.D.O.		23b. ADDRESS Marshfield, Mo.	23c. DATE SIGNED 6/26/54
24a. BURIAL: CREMATION REMOVAL (Specify) Removal	24b. DATE 6-28-1954	24c. NAME OF CEMETERY Jamison	24d. LOCATION (City, town, or county) (State) Osceola Iowa
DATE REC'D BY LOCAL REG. 7-13-54	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Barber Funeral Home Marshfield Mo.	

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.....
Signature of Student Embalmer

Signed *John S. Williams*.....

Licensed Embalmer No. *465*

P. O. Address *Massfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.