

FILED OCT 13 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32747

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 224 PRIMARY REG. DIST. NO. 3072 Registrar's No. 1604

0972

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Marshall, Mo.</b>		c. CITY OR TOWN <b>Marshall</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>8 Yrs.</b>		e. STREET ADDRESS (If rural, give location) <b>33 West Porter</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>33 West Porter</b>			

0972

3. NAME OF DECEASED (Type or Print) a. (First) <b>Clora</b> b. (Middle) <b>Ann</b> c. (Last) <b>Breshears</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 5 1954</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 23-1886</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Dallas Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Lafayette McKee</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Scott</b>	14. NAME OF HUSBAND OR WIFE <b>John C. Breshears</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Opal Newton-Marshall</b> ADDRESS <b>Missouri</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary artery disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive arteriosclerotic</b> DUE TO (c) <b>Cardio-vascular disease</b>		
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	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) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **26 Mar 1954**, to **5 Oct 54**, that I last saw the deceased alive on **5 Oct. 1954**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Kath H. Wroe</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Marshall, Mo.</b>	23c. DATE SIGNED <b>10-6-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10/8/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>mt. Carmel</b>	24d. LOCATION (City, town, or county) (State) <b>5 mi. north - Marshall, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>10.7.1954</b>	REGISTRAR'S SIGNATURE <b>Sidney J. Gray</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Leslie Swanson</b> ADDRESS <b>Marshall, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MS  
MAY 17 1959

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..... *J. Lechi Susman*

Licensed Embalmer No. ....

P. O. Address. *Manhasset*

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.