

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37170**

No. 300
10.48

FILED DEC 13 1954

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **88**

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

1. PLACE OF DEATH a. COUNTY HENRY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY HENRY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLINTON		c. LENGTH OF STAY (In this place) 2 months	
d. FULL NAME OF HOSPITAL OR INSTITUTION MOORES REST HOME		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BLAIRSTOWN 0420	
		d. STREET ADDRESS (If rural, give location) GEN. DELIVERY 0	
3. NAME OF DECEASED (Type or Print) SOPHIA		4. DATE OF DEATH (Month) (Day) (Year) DEC. 8 1954	
a. (First) SOPHIA		b. (Middle) K	
c. (Last) WESTENDORF			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 3 1875
9. AGE (In years last birthday) 79		10. MONTHS 3	11. DAYS 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME SPREEN		13b. MOTHER'S MAIDEN NAME ZINKNOWN	
14. NAME OF HUSBAND OR WIFE DECEASED			
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 MAUDE SIMPSON		ADDRESS BLAIRSTOWN	
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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemiplegia right		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) Cerebral hemorrhage		6 months	
DUE TO (c) Arteriosclerosis		Unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile dementia		6 months	
19a. DATE OF OPERATION No		19b. MAJOR FINDINGS OF OPERATION 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		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) No		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 Oct 11 1954 , to Dec 8 1954 , that I last saw the deceased alive on Dec 1 1954 , and that death occurred at 11 A m., from the causes and on the date stated above.			
23a. SIGNATURE S. B. [Signature]		23b. ADDRESS Clinton Mo.	
23c. DATE SIGNED 12/9/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 12/10/54	
24c. NAME OF CEMETERY OR CREMATORY BLAIRSTOWN		24d. LOCATION (City, town, or county) (State) HENRY COUNTY MO.	
DATE REC'D BY LOCAL REG. Dec-10-54		REGISTRAR'S SIGNATURE Florence Adair	
FUNERAL DIRECTOR'S SIGNATURE Fred Wilkinson		ADDRESS Funeral Home	

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

F. L. Schaberg

Licensed Embalmer No. *4513*

P. O. Address *Clinton 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.