

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **41341**

No. 300
10-48

FILED JAN 4 - 1956

BIRTH NO. _____ REG. DIST. NO. **207** PRIMARY REG. DIST. NO. **5756** Registrar's No. **79**

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

1. PLACE OF DEATH a. COUNTY Maries		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Maries	
b. CITY OR TOWN Rural (Jefferson County)		c. CITY OR TOWN Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Family Home		e. STREET ADDRESS (If rural, give location) near Belle, Mo.	
3. NAME OF DECEASED (Type or Print) EVA		4. DATE OF DEATH (Month) (Day) (Year) Dec-23-1955	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH Aug 14-1883	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper	
10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME THOMAS TRAVIS	
13b. MOTHER'S MAIDEN NAME SUZANNA ROGERS		14. NAME OF HUSBAND OR WIFE	
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 Norma Travis - Belle - Mo.		ADDRESS	
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) Cerebral Vascular Accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchial Pneumonia DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 4 days 3 days	
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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/18, 1955</u>, to <u>12/23, 1955</u>, that I last saw the deceased alive on <u>12/23, 1955</u>, and that death occurred at <u>8:30 a.m.</u>, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. H. Schoups, M.D.		23b. ADDRESS Belle, Mo.	
23c. DATE SIGNED 12/24/55		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 12-25-55		24c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery	
24d. LOCATION (City, town, or county) (State) Belle - Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Seneca, Mo.	
DATE REC'D BY LOCAL REG. 12-26-55		REGISTRAR'S SIGNATURE Pauline Howard	

JAN 4

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 *Cherita Dassenman*

Licensed Embalmer No. *417*

P. O. Address *Blend -*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.