

Health, Welfare Public Service

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All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 21 1956

38787

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 5764 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <b>MARION</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MARION</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>WARREN TOWNSHIP</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>MONROE CITY</b> 0640 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MONROE CITY #3</b> Length of stay in lb <b>LIFE TIME</b>		d. STREET ADDRESS (If outside, give location) <b>RFD #3</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>MARY ELIZABETH MORTLAND.</b> First Middle Last			4. DATE OF DEATH <b>OCTOBER 6 1956</b> Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 20<sup>th</sup> 1879</b>	9. AGE (In years last birthday) <b>77</b> IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b> IF UNDER 24 HRS. Hours <b>7</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>		11. BIRTHPLACE (City and state or country) <b>MARION County Missouri</b>		
13. FATHER'S NAME <b>WILLIAM HENRY HIBBERT</b>			14. MOTHER'S MAIDEN NAME <b>Josephine MASTON.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Josephine M. Glendon</b> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of large uterine myoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
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21. I attended the deceased from **September 1954, to October 5, 1956** and last saw her <sup>alive</sup> on **October 5, 1956**  
Death occurred at **4 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Charles R. Johnson MD</b>	22b. ADDRESS <b>211 No. Main - Monroe City, Mo.</b>	22c. DATE SIGNED <b>10-6-56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct 8 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ANDREW CHAPEL Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Marion County Missouri</b>
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24. FUNERAL DIRECTOR <b>WILSON &amp; SONS, Monroe City, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-8-56</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lupton</b> <b>By Viola Sec. Deputy</b>
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RECEIVED NOV 20 1956  
MARION CO. HEALTH DEPT.  
DATE FILED NOV 20 1956

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 me....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Lester L. Wilson.....

Licensed Embalmer No. 301

P. O. Address Marion Co.

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