THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42015
STATE FILE NUMBER

FILED DEC 19 1956

Registration District No. 170 Primary Registration District No. 5630 Registrar's No. 196

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon T. S. Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lebanon Rt. 1 Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Mo b. COUNTY Laclede
c. CITY OR TOWN Lebanon Inside Limits Yes ☐ No ☒
d. STREET ADDRESS Rt. 1 (If outside, give location) Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Mary Middle E Last Wright
4. DATE OF DEATH Month Dec. Day 11 Year 1956
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 18 1869
9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Fort Worth Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Robt. Newberry
14. MOTHER'S MAIDEN NAME Sarah Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Mrs. Earnest Brown Lebanon Mo. Rt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Heart Disease — 1 year.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 443X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Sept. 56 to Dec. 10, 56 and last saw her/him alive on 12-10-56
Death occurred at 5.20 A on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE H. W. Carrington M.D. (Degree or title)
22b. ADDRESS Lebanon, Mo.
22c. DATE SIGNED 12-12-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12/13/56
23c. NAME OF CEMETERY OR CREMATORY Similan
23d. LOCATION (City, town, or county) (State) Laclede Co. Mo.
24. FUNERAL DIRECTOR S.R. Palmer ADDRESS Lebanon mo
25. DATE RECD. BY LOCAL REG. 12-13-1956
26. REGISTRAR'S SIGNATURE Nella L. Hay

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Received 12-17-56

Laclede County Health Unit

File No. 196

Date Filed 12-17-56

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was er

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed S. R. Palmer

Licensed Embalmer No. 2

P. O. Address Lebon

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.