

FILED FEB 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1162

STATE FILE NUMBER

Registration District No. 142 Primary Registration District No. 5386 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Goldsberry Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Mountain View</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>None - Home</u>		Length of stay in 1b <u>Years</u>	d. STREET ADDRESS (If outside, give location) <u>Star Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>May</u> Last <u>Hamer</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Ord, Nebraska</u>
13. FATHER'S NAME <u>Jasher Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Sydia Ann Stephens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Martha Mock - Mountain View, Mo.</u> 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) <u>EMBOLISM</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>DECOMPENSATION MYOCARDIAL</u> DUE TO (c) <u>ATRIAL FIBRILLATION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>GOITRE NODULAR NON TOXIC</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u> <u>CHRONIC</u> <u>RECURRENT</u>
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 <u>9:00</u> a. m. <u>7</u> p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>1/9/57</u> to <u>1/31/57</u> and last saw her <u>alive</u> on <u>1/31/57</u> Death occurred at <u>9:00</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. B. Perkins, M.D.</u>		22b. ADDRESS <u>Wallow Springs, Mo.</u>	22c. DATE SIGNED <u>2/6/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-3--1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mountain View, Mo.</u>
24. FUNERAL DIRECTOR <u>Duncan Funeral Home-Mtn. View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without.00
56th,
office
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vice

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 *Joel R. Linn*

Licensed Embalmer No. *432*

P. O. Address *1017 1/2*

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.