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ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3421

FILED FEB 4 1957

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>Sullivan</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Cora - Rural</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>Sull. Co. Mem. Hosp</u>			Length of stay in lb <u>1 week</u>	d. STREET ADDRESS (If outside, give location) <u>Duncan Twp</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Louyena Almond</u>				First	Middle	Last	4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F. m</u>	6. COLOR OR RACE <u>w</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>3-17-1905</u>		9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>near Milan - Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>Albert H. Hennen</u>				14. MOTHER'S MAIDEN NAME <u>Emmy Frazier</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ova Almond, Cora 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>Toxicity from tubercule Co. fungus</u> <u>Stimulation for Cu / tuberc</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>8 mos</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						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.								
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 <u>St Louis Sullivan Mo</u>		COUNTY STATE		
21. I attended the deceased from <u>Dec 15</u> to <u>5 p</u> and last saw her alive on <u>11/29/57</u>				Death occurred at <u>6:13</u> <u>4</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Approve or title) <u>A. J. Beckett</u>				22b. ADDRESS <u>St Louis Mo</u>		22c. DATE SIGNED <u>1/23/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Oak Cem.</u>		23d. LOCATION (City, town, or county) <u>Cora Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>Schroeder</u> <u>Doright Schroeder</u>		ADDRESS <u>Milan - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-28-57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Dwight Schoene*.....

Licensed Embalmer No. *26*

P. O. Address *Nolan*.....

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.