

Health, Welfare, Public Service
 300
 -56
 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 their report. No symptoms will be listed. AT
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 27 1957

STANDARD CERTIFICATE OF DEATH

12336

STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. 6139 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Shelby</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BLACK CREEK</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Shelbyville</u>		1020 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb	d. STREET ADDRESS (If outside, give location)				
3. NAME OF DECEASED (Type or print) <u>MABLE</u>			First	Middle <u>C</u>	Last <u>Wood</u>	4. DATE OF DEATH Month <u>Feb</u> Day <u>17</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>Feb 26 1886</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>23</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>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>OAK DALE MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Broughton</u>				14. MOTHER'S MAIDEN NAME <u>ZANTIPPIC DENNIS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>R. A. Wood Shelbyville Mo</u>				
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>Cerebral thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Cerebral thrombosis and hypertension</u>					331x	
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>She had a Rt Sided hemiplegia about 16 months ago</u>							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 <u></u> a. m. <u></u> p. m. <u></u>	Month <u></u> Day <u></u> Year <u></u>							
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	
21. I attended the deceased from <u>Feb-14-57</u> to <u>Feb-17-57</u> and last saw <u>her</u> alive on <u>Feb-17-57</u> Death occurred at <u>2:20</u> <u>P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>R. G. Beckett M.D.</u>				22b. ADDRESS <u>Shelbyville, Mo</u>		22c. DATE SIGNED <u>2-20-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb-19-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK DALE Cemetery</u>		23d. LOCATION (City, town, or county) <u>Shelby county MO</u>		(State)		
24. FUNERAL DIRECTOR ADDRESS <u>E. P. Thompson Shelbyville Mo</u>			25. DATE RECD. BY LOCAL REG. <u>2-25-57</u>		26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 *C. W. Musgro*

Licensed Embalmer No. *2*

P. O. Address *Bethel*

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.