

Health, Welfare, Public Service
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 1-56
 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
 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.
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THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED APR 1 - 1957

8466
 STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 116

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Colo.</u> b. COUNTY <u>8050</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville 4</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Denver, Colo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Nursing Home, Mo.</u>			Length of stay in lb		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ALLie</u> Middle _____ Last <u>Willard</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1870</u>		9. AGE (In years last birthday) <u>86</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
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. BIRTH PLACE (City and state or country) <u>Adair Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Lantz</u>				14. MOTHER'S MAIDEN NAME <u>Laura Hawkins</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 _____ 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>Acute Circulatory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thyrototoxicosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Median 5 days</u> <u>unknown</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 _____ Month _____ Day _____ Year _____ 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		COUNTY		STATE	
21. I attended the deceased from <u>Oct 25, 1956</u> to <u>March 21, 1957</u> and last saw <u>her</u> alive on <u>March 21, 1957</u> Death occurred at <u>1:45 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>George H. Scheurer, D.O.</u>				22b. ADDRESS <u>Kirkville Mo.</u>		22c. DATE SIGNED <u>3-26-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-23-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stuber Cem.</u>		23d. LOCATION (City, town, or county) <u>Adair Co. Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Doris Davis, Kirkville, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>3-26-1957</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Rathoff</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 *Robert B. Davis*

Licensed Embalmer No. *42*

P. O. Address *Hubert*

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.