

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7569

FILED MAR 19 1957

STATE FILE NUMBER

Registration District No. 32 Primary Registration District No. 4042 Registrar's No. 17

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             |                                                                                                             |                                                                                                                                             |                                                                           |                                                                               |                                                                                      |                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Bollinger</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                             |                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br><u>Missouri</u> STATE <u>Cape Girardeau</u> COUNTY |                                                                           |                                                                               |                                                                                      |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>Lutesville Mo</u>                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                        | c. CITY<br>OR<br>TOWN <u>Cape Girardeau 016</u>                                                                                             |                                                                           |                                                                               | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                                                                       |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bond Nursing Home</u>                                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                                                                             | Length of stay in 1b<br><u>3 months</u>                                                                                                     |                                                                           | d. STREET ADDRESS (If outside, give location)<br><u>R.F.D.#2</u>              |                                                                                      | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Martha</u> Middle <u>W</u> Last <u>Floyd</u>                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>3</u> Year <u>1957</u>                                        |                                                                                                                                             |                                                                           |                                                                               |                                                                                      |                                                                                       |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July, 29, 1873</u>                                                                   |                                                                                                                                             | 9. AGE (In years last birthday)<br><u>83</u>                              | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>                                     |                                                                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>                                                                                                                                                                                                                                                                                                                                                               |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>                                                                                                            |                                                                                                             | 11. BIRTHPLACE (City and state or country)<br><u>Cape Girardeau Mo</u>                                                                      |                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                    |                                                                                      |                                                                                       |
| 13. FATHER'S NAME<br><u>Detrich Schrader</u>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Minnie Vorweg</u>                                                                                            |                                                                           |                                                                               |                                                                                      |                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                         |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                                                                      |                                                                                                             | 17. INFORMANT<br><u>Walter Haman Cape Girardeau, Mo.</u> Address                                                                            |                                                                           |                                                                               |                                                                                      |                                                                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asymptotic Pneumonia</u><br>DUE TO (b) <u>Cerebral Hemorrhage</u><br>DUE TO (c) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |                                                                                                                                                             |                                                                                                             |                                                                                                                                             |                                                                           | INTERVAL BETWEEN ONSET AND DEATH                                              |                                                                                      |                                                                                       |
| 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.)<br><u>331X</u> |                                                                                                                                             |                                                                           |                                                                               |                                                                                      |                                                                                       |
| 20c. TIME OF INJURY<br>Hour <u>    </u> Month <u>    </u> Day <u>    </u> Year <u>    </u><br>a. m. <u>    </u> p. m. <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<br><u>Lutesville Mo</u>                                                                                        |                                                                           | COUNTY STATE                                                                  |                                                                                      |                                                                                       |
| 21. I attended the deceased from <u>1/4/57</u> to <u>3/3/57</u> and last saw her <u>him</u> alive on <u>    </u><br>Death occurred at <u>3/2/57</u> <u>    </u> m on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                                                                             |                                                                                                                                             |                                                                           |                                                                               |                                                                                      |                                                                                       |
| 22a. SIGNATURE (Degree or title)<br><u>John J. Myers M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                                                                                             | 22b. ADDRESS<br><u>Lutesville Mo</u>                                                                                                        |                                                                           | 22c. DATE SIGNED<br><u>3/4/57</u>                                             |                                                                                      |                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  | 23b. DATE<br><u>3/5/57</u>                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park Cemt</u>                                             |                                                                                                                                             | 23d. LOCATION (City, town, or county) (State)<br><u>Cape Girardeau Mo</u> |                                                                               |                                                                                      |                                                                                       |
| 24. FUNERAL DIRECTOR<br><u>L.L. Haman Cape Girardeau Mo</u> ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br><u>3-16-57</u>                                                              |                                                                                                                                             | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. Buford Crader</u>                    |                                                                               |                                                                                      |                                                                                       |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

800-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no reason. All diseases in Part I must be casually related.

MEDICAL CERTIFICATION

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 L. L. Haman .....

Licensed Embalmer No. 2863

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure  
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.