

Health, Welfare
Public
Service

300
1-56

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7957
STATE FILE NUMBER

FILED APR 11 1957

Registration District No. 65 Primary Registration District No. 4115 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Chariton</u> <u>210</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Chariton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Triphett</u>		c. CITY OR TOWN <u>Triphett</u> <u>0210</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PEARL</u> Last <u>CLARK</u>			4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>F</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>JULY 14-1880</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Month <u>8</u> Days <u>22</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>Housework</u>		11. BIRTH PLACE (City and state or country) <u>INDIANA</u>	
13. FATHER'S NAME <u>O.C. EARLEYWINE</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca SCHAAF</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>R.L. CLARK Triphett 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>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>10 yrs</u> <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>		
	DUE TO (c) <u>Hypertension</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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 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	COUNTY STATE

21. I attended the deceased from <u>July 56</u> to <u>April 6 57</u> and last saw her <u>alive</u> on <u>April 6 57</u> . Death occurred at <u>April 6 9 a m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W.H. Fowler M.D.</u>		22b. ADDRESS <u>Brunswick Mo</u>	22c. DATE SIGNED <u>4-7-57</u>
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-8-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McCullough</u>	23d. LOCATION (City, town, or county) (State) <u>Triphett Mo</u>
24. FUNERAL DIRECTOR <u>S.A. Allpard</u>	ADDRESS <u>Mendon Mo</u>	25. DATE RECD. BY LOCAL REG. <u>April 8-57</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Brasse</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 *A. L. Shepard*

Licensed Embalmer No. *39*

P. O. Address *Mendon*

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.