

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9416

FILED APR 8 - 1957

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 5762 Registrar's No. 9

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

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Durham - Round Grove</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Durham</u> <u>0640</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		d. STREET ADDRESS (If outside, give location) <u>4 miles S.W.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>TOLA</u> Last <u>WAGGNER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</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>10-6-89</u>
9. AGE (In years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</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>Farm</u>	
11. BIRTHPLACE (City and state or country) <u>Emerson Mo. Marion</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Barkley Hutcherson</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda H. Gyllinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Irm Stout</u>		Address <u>Hannibal</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 Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>4201</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>2 P</u> Month <u>Mar</u> Day <u>1</u> Year <u>1957</u> 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>Mar 1 - 1957</u> to <u>Mar 31</u> and last saw her/him alive on <u>Mar 31 - 57</u> Death occurred at <u>2 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Palmyra Mo</u>	
22c. DATE SIGNED <u>4/2/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>April 3, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Emerson</u>		23d. LOCATION (City, town, or county) (State) <u>In Emerson Mo</u>	
24. FUNERAL DIRECTOR <u>Thomas Bell</u> ADDRESS <u>Ewing, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-3-57</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		By <u>Vivian Green</u> Deputy	

(Licensed Embalmer's Statement on Reverse Side)

1890

RECEIVED APR 4 1957
MARION CO. HEALTH DEPT.
DATE FILED APR 4 1957

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. M. Cralich*.....

Licensed Embalmer No. *4905*.....

P. O. Address *Evings, Mo.*.....

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.