

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10177

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2907

Health,
& Welfare
Public
ServiceS. 300
S. 1-56

securing the medical certification in the specific manner required by 193.140 MORS 1949.
 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 | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Calaway | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Rural | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital | | Length of stay in 1b 2mos. | | 31 STREET ADDRESS RFD #1 | | (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Eureth First NMI Middle DOANE Last | | | | 4. DATE OF DEATH Month Mar Day 26 Year 1957 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-19-82 | | 9. AGE (In years last birthday) 74 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Monroe Co. Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Grant | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address St. Lukes Hosp. records. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of cerebral artery (Basilar) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension | | | | | | INTERVAL BETWEEN ONSET AND DEATH 39 days 4/2 4/2 | |
| 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"/> 2 | |
| 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.) 332x | | | | |
| 20c. TIME OF INJURY Hour 3:50 Month, Day, Year | | | | | | | |
| 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 Dec 9 '38 to Mar 26-1957 and last saw her alive on Mar 21-1957 . Death occurred at 3:50 a. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Raymond Williams M.D. | | | | 22b. ADDRESS 114. No Taylor St. Louis 8 | | 22c. DATE SIGNED 26 Mar 57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE March 29, 1957 | 23c. NAME OF CEMETERY OR CREMATORY Mount Hope, Cemetery | | 23d. LOCATION (City, town, or county) (State) Joplin, Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS Wallace Funeral Home Fulton, Mo. | | | 25. DATE RECD. BY LOCAL REG. MAR 26 '57. | | 26. REGISTRAR'S SIGNATURE J. Carl Smyth, M.D. | | |

(Licensed Embalmer's Statement on Reverse Side)

APR 15 1951

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 *Hector R. Masum*

Licensed Embalmer No. *499*

P. O. Address *Fulton*

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.