

FILED APR 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14326

STATE FILE NUMBER

Registration District No. 099 Primary Registration District No. 6025 Registrar's No. 5Health,
Welfare
Public
Service0900
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 casually 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>IRON Reynolds</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> COUNTY <u>Reynolds</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Black-Black River</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Black</u> <u>0900</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <u>Home at Black Mo</u> <u>5 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>--</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ila</u> Middle <u>Blanche</u> Last <u>Faulkner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 29 1909</u>
9. AGE (In years last birthday) <u>48</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></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>x</u>	11. BIRTHPLACE (City and state or country) <u>Dent Co Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		13. FATHER'S NAME <u>Gentry Messer</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Brooks</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <u>No</u> <u>x</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Iyrin Faulkner Black 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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>few hrs</u> <u>Earl Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 <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>4/8/57</u> to <u>4/10/57</u> and last saw her ^{her} him alive on <u>4/8/57</u> Death occurred at <u>9.30</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>G. M. Huppachek MD</u>		22b. ADDRESS <u>Pesterville Mo</u>	
22c. DATE SIGNED <u>4/10/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>April 12 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Boss Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Boss Dent Co Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Orl H. Spuman Palm Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4/10/57</u>	
26. REGISTRAR'S SIGNATURE <u>G. M. Huppachek</u>			

(Licensed Embalmer's Statement on Reverse Side)

Received 4-15-57
Foye County Health Center
File No. 257 - 14

JAN 13 1959

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.....
Carl H. Johnson

Licensed Embalmer No. *237*

P. O. Address.....
Dalton, Va.

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.