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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

FILED MAY 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16544

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 168

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cole</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CAMDEN</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Sumner Beach</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 <u>Chas. Still Hospt.</u> | | Length of stay in lb <u>12 days</u> | d. STREET ADDRESS <u>Star Rt</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>MARA</u> Middle <u>JOSEPHINE</u> Last <u>CLOS</u> | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1957</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-30-1888</u> | | 9. AGE (In years last birthday) <u>57</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 | | 11. BIRTHPLACE (City and state or country) <u>Prairie Home, Iowa U.S.A.</u> | |
| 13. FATHER'S NAME <u>FREEMAN, JOE</u> | | | 14. MOTHER'S MAIDEN NAME <u>BROWN, MINNIE</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT <u>LAWRENCE CLOS SUMNER BEACH, MO.</u> | |

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|---|--|---|
| 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>Ventricular fibrillation</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>120 sec.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>myocardial infarction</u> | | <u>12 days.</u> |
| DUE TO (c) <u>acute coronary occlusion</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease 4200</u> | | |

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|---|--|--|--|--|--|
| 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>7:35</u> Month <u>5</u> Day <u>17</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 <u>Sumner Beach, MO.</u> | |
| 21. I attended the deceased from <u>5/5/57</u> to <u>5/17/57</u> and last saw her/him alive on <u>5/16/57</u> Death occurred at <u>7:35 A</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>420 E. High St.</u> | | 22c. DATE SIGNED <u>5/17/57</u> | |

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|--|--|-----------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>19 MAY 57</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>VERSAILLES</u> | |
| 24. FUNERAL DIRECTOR <u>W. F. Radwell</u> | | ADDRESS <u>VERSAILLES, MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>18 May, 1957</u> | |
| 26. REGISTRAR'S SIGNATURE <u>R. J. Davis, M.D. - M.P.</u> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

1957 JUN 26 10:08 AM '57

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 *Raymond C. Locker*

Licensed Embalmer No. *462*

P. O. Address *Versailles*

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.