

Health,
Welfare
Public
Service

300
1-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16600

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. 5345 Registrar's No. 57-37

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sac Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Sac Twp</u> <u>0290</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>2 1/2 mi E of Arcola, Mo</u>			Length of stay in lb <u>6 mos.</u>		d. STREET ADDRESS (If outside, give location) <u>2 1/2 mi E of Arcola, Mo</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ETTIE</u> Middle <u>Adelia</u> Last <u>Reed</u>				4. DATE OF DEATH <u>June 1-1957</u> Month <u>June</u> Day <u>1</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>June 20-1871</u>		9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</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>Housekeeping</u>		11. BIRTHPLACE (City and state or country) <u>Polk Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Simmons</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>None</u>		17. INFORMANT <u>Jessie Mitchell, Everton, Mo</u> Address				
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>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Contributor chronic bronchitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH	
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 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>5/1-57</u> to <u>June 1, 1957</u> and last saw <u>her</u> alive on <u>5/26-57</u> Death occurred at <u>5:05 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>W. S. Buehner M. A.</u> (Degree or title)				22b. ADDRESS <u>Miller, Mo.</u>		22c. DATE SIGNED <u>6-3-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 3, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashford Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Arcola, Mo.</u>			
24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>6-3-57</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</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 en

by me, ~~or by~~ Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed *J. C. Canada*
Licensed Embalmer No. *41*

P. O. Address *Greenfield*

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.