

Health, Welfare, Public Service
 300
 1-56
 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
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

FILED JUL 15 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

19932
 STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 5004 Registrar's No. 245

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Novinger - NINEVEH</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Novinger</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>at home</u>			Length of stay in lb <u>0040</u>		STREET ADDRESS <u>R. F. D.</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Agnes</u> Last <u>Stiles</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</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>Sept. 20, 1886</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. 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>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Adair County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jehu Bybee</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Bray</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>491 14 2176</u>		17. INFORMANT <u>Mrs. Golda Bartosik, Shelbina, 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>Carcinoma of Intestines</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</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 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>June 1-59</u> and last saw him alive on <u>July 4-57</u> Death occurred at <u>9:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated							
22a. SIGNATURE <u>A. H. Garrison</u> (Degree or title)				22b. ADDRESS <u>Novinger</u>		22c. DATE SIGNED <u>7-5-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/6/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Novinger Cemetery</u>		23d. LOCATION (City, town, or county) <u>Novinger, Mo.</u> (State)		
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Kirksville, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-8-1957</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</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 embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Kenneth E. Hayes*

Licensed Embalmer No. *489*

P. O. Address *Kimbrell*

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.