

Health, Welfare and Public Service  
 300  
 -57  
 1  
 Doctor, coroner, etc. must use only standard nomenclature to treat 18. No symptoms with no previous  
 All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 79  
 0

FILED JUN 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

20884

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 58

1. PLACE OF DEATH a. COUNTY <u>Lowell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lowell</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Mo. Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Barrett</u> Last <u>Foy</u>			4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1957</u>
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wht</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>6-15-1888</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>29</u>	9c. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>John Barrett</u>		13b. MOTHER'S MAIDEN NAME <u>Agnes Weatherly</u>	14. NAME OF HUSBAND OR WIFE <u>H.A. Foy</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>H.A. Foy West Plains Mo.</u> Address <u></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>congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>			
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"/>
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.) <u>4341</u>	
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 Death occurred at <u>7 Apr 1957 4:30 P</u>		and last saw her alive on <u>13 June 1957</u>	
22a. SIGNATURE (Degree or title) <u>Beatrice Cook</u>		22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>18-6-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-16-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town or county) (State) <u>West Plains Mo.</u>
24. FUNERAL DIRECTOR <u>Robertson West Plains Mo</u> ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>6-20-57</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

(Licensed Embalmer's Statement on Reverse Side)  
Edw. Allen Smith

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 *L. J. Drago* .....

Licensed Embalmer No. *4547* .....

P. O. Address .....

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.