

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20893

State File No. \_\_\_\_\_

FILED JUN 18 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 143 PRIMARY REG. DIST. NO. 4232 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Willow Springs,</b>		c. LENGTH OF STAY (in this place) <b>5 yrs</b>	c. CITY OR TOWN <b>Willow Springs</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Dale Nursing Home</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>0460</b> (If rural, give location) <b>0</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b> b. (Middle) <b>MINERVA</b> c. (Last) <b>CONE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 3, 1957</b>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Sept. 18, 1872</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Melbourne, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		

13a. FATHER'S NAME <b>Jim Clift</b>		13b. MOTHER'S MAIDEN NAME <b>Wilson</b>		14. NAME OF HUSBAND OR WIFE <b>Thomas Franklin Cone</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Wilson Cone, Pomona, Missouri</b>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b>				<b>Days</b>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <b>Stasis and Pulmonary Edema</b>			<b>months</b>
	DUE TO (c) <b>Arterio sclerotic Heart Disease</b>			<b>years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<b>Generalized Arteriosclerosis + residual CVA</b>			<b>years</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I attended the deceased from Mar. 19 02 to 3 June, 1957, that I last saw the deceased alive on 3 June, 1957, and that death occurred at 9:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>L.E. Walker</b> (Degree or title)	23b. ADDRESS <b>Hedital Clinic Willow Springs, Mo.</b>	23c. DATE SIGNED <b>6/10/57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>Jun. 6, 1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mackey Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Pomona, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>6/15/57</b>	REGISTRAR'S SIGNATURE <b>Margaret P. ...</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hal ... West Plains, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

THORNBURGH FUNERAL HOME  
WEST PLAINS, MO.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....  
*Hal Thomsen*

Licensed Embalmer No. *340*

P. O. Address *W. Plain*

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.