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 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED JUL 1 1957

021770
 STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 244

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Marceline</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Marceline</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 <u>127 W. Calif.</u>		Length of stay in lb <u>5 yr.</u>		d. STREET ADDRESS (If outside, give location) <u>127 W. Calif.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>J.</u> Last <u>Pemberton</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>10-9-1888</u>		9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>5</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></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>New Frankfurt, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Deaver</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>495-05-9773</u>		17. INFORMANT <u>Gorden Pemberton</u> Address <u>Marceline, Mo.</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>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</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 <u>12 hours</u> <u>4 years</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.) <u>4201</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 <u>Jan 1 1953</u> to <u>Jan 13 1957</u> and last saw her alive on <u>Jan 9 1957</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John Otis Carr D.O.</u>				22b. ADDRESS <u>Marceline Mo</u>		22c. DATE SIGNED <u>6/15/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>6-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT 91101</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline, Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>James McLaughlin Marceline, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>6-17-57</u>		26. REGISTRAR'S SIGNATURE <u>Brookiel Owens</u>	

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 *James B. McClelland*

Licensed Embalmer No. *42*

P. O. Address *Brookly*

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.