

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23495  
STATE FILE NUMBER

FILED JUL 16 1957

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 80

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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

1. PLACE OF DEATH a. COUNTY <u>Bates</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Butler</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Butler</u> <u>00710</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>308 N. Main</u>			Length of stay in 1b <u>33 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>308 N. Main</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Blanche</u> Last <u>Stanley Noe</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</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>Oct 16 - 1888</u>		9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>8</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>Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (City and state or country) <u>Wodge City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Rev. Cyrus W. Stanley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Haynes</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>500-383919</u>		17. INFORMANT <u>Dr. Stanley Noe</u> Address <u>Butler 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>Acute Coronary Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Generalized Arteriosclerosis</u>		DUE TO (c) <u>Arterial Hypertension</u>		15 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 a. m. <u>Hour</u> p. m. <u>Month, Day, Year</u>									
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>several years</u> to <u>June 17, 1957</u> and last saw <u>her</u> alive on <u>June 17, 1957</u> Death occurred at <u>8:40 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Dexter W. Lusk, M.D.</u> (Degree or title)				22b. ADDRESS <u>Butler MO</u>				22c. DATE SIGNED <u>6/18/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6-19-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakhill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Butler Mo.</u>			
24. FUNERAL DIRECTOR <u>Culver Underwood</u> ADDRESS <u>Butler Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>June 19 1957</u>		26. REGISTRAR'S SIGNATURE <u>Kendall Kersey</u>			

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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 ex-  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert G. Steenbeck*

Licensed Embalmer No. *46*

P. O. Address *Butte*

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.