

Health, Welfare, Public Service

00
57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FILED SEP 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27939

STATE FILE NUMBER

Registration District No. 106 Primary Registration District No. 5420 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY Dunklin			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dunklin		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Holcomb Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Holcomb, Missouri		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Holcomb, Mo. Rt. 1		Length of stay in lb 10 days	d. STREET ADDRESS Rte. 1		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARTHA Middle VICTORIA Last WRIGHT			4. DATE OF DEATH Month Aug. Day 23 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1875	9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Travis Cooper		13b. MOTHER'S MAIDEN NAME Martha Henson		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Clarence Wright, Holcomb, Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Generalized Arteriosclerosis		DUE TO (c) ? years.	
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 4/25/57 to 8/20/57 and last saw her ^{him} alive on 8/20/57 Death occurred at 1:30 :A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Wallace Belsey M.D.			22b. ADDRESS Campbell Mo.		22c. DATE SIGNED 8/27/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-25-57	23c. NAME OF CEMETERY OR CREMATORY Canaan Cemetery		23d. LOCATION (City, town, or county) (State) Gibson, Missouri
24. FUNERAL DIRECTOR Landess Funeral Home, Campbell, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. 9-7-57	26. REGISTRAR'S SIGNATURE J. A. Anderson	

RECEIVED DUNKLIN COUNTY HEALTH
DEPARTMENT 9-10
COUNTY FILE NUMBER 957

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 *Christina M. Lander*

Licensed Embalmer No. 4227

P. O. Address *Campbell*

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.