

Health, Welfare, Public Service

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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

28698
STATE FILE NUMBER

FILED AUG 19 1957

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 200

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHILlicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MEADVILLE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SUSAN'S NURSING HOME</u> Length of stay in lb <u>1 YR</u>		d. STREET ADDRESS (If outside, give location) <u>2 MILES E. OF TOWN</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>FLORENCE</u> Last <u>VANNESS</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>4-12-1875</u>	9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
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 <u>—</u>	11. BIRTHPLACE (City and state or country) <u>WILLISBURG, KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT COMLEY</u>			14. MOTHER'S MAIDEN NAME <u>BETTY FARRAE</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>NONE</u>	17. INFORMANT Address <u>MARY ROZE, MEADVILLE, 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>CARDIAC Arrest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral vascular Accident</u>		<u>2 wks.</u>
	DUE TO (c) <u>Senility</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>331X</u>		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 <u>12:10</u> Month <u>Aug</u> Day <u>12</u> Year <u>1957</u> 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 Aug 12, 1956 to Aug 12, 1957 and last saw her/him alive on Aug 12, 1957
Death occurred at 12:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. W. Matheny D.O.</u>	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>8/12/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>McLEAN ILLINOIS</u>
24. FUNERAL DIRECTOR ADDRESS <u>BROTHERS, MEADVILLE, MO</u>	25. DATE RECD. BY LOCAL REG. <u>8/12/57</u>	26. REGISTRAR'S SIGNATURE <u>Francis B. Nail</u> <u>BROTHERS, MEADVILLE, MO</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..... *W. R. Wright*

Licensed Embalmer No. *465*

P. O. Address *Meadville*

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.