

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32686

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 956

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. *If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY, <u>ROLLS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>HANNIBAL</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY - OR TOWN <u>MONROE CITY R.F.D. 2</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>ST ELIZABETH HOSPITAL</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>AGNES</u> Last <u>YOUNG</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>14</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>AUGUST 1, 1867</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>13</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>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ROLLS COUNTY, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>RICHARD O BRYAN</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH JONES</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>McDonary Collier</u> Address <u>Lohman, 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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ASVD - Hypertension</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) <u>4200</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></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></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 <u>MONROE CITY</u> COUNTY <u>MISSOURI</u> STATE <u></u>
21. I attended the deceased from <u>Jan 1 - 56</u> to <u>9-14-57</u> and last saw her ^{her} _{alive} on <u>8-15-57</u> . Death occurred at <u>8:10 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>[Address]</u>	22c. DATE SIGNED <u>9-16-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-16-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MONROE CITY, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>Wilson & Son</u> ADDRESS <u>Monroe City, MO</u>	25. DATE RECD. BY LOCAL REG. <u>9/16/1957</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embolper's Statement on Reverse Side)

RECEIVED SEP 19 1957
MARION CO. HEALTH DEPT.
DATE FILED SEP 19 1957

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 *Lester L. Wilson*

Licensed Embalmer No. *2017*

P. O. Address *Marion Co. Ky*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.