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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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

32743

STATE FILE NUMBER

Registration District No. 236 Primary Registration District No. 5818 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>McLean</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Morgan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Normal</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>Smiles South Versailles</u>			Length of stay in lb <u>45 minutes</u>		d. STREET ADDRESS (If outside, give location) <u>1004 Fell Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>M.</u> Last <u>Small</u>				4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>September 1, 1928</u>		9. AGE (In years last birthday) <u>29</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>8</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>UNKNOWN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and state or country) <u>Chicago Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew KOVAL</u>				14. MOTHER'S MAIDEN NAME <u>MARY Kovacs</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>350-20-4524</u>		17. INFORMANT <u>W. J. Hargreaves</u> Address <u>Colfax Ill</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>Fracture, Cervical Vertebrae</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> DUE TO (b) <u>Head-on collision, car wreck</u> <u>20 min.</u> DUE TO (c) <u>8164</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>26</u>								
20a. ACCIDENT <input checked="" 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>Head-on collision, two cars, 4 mi. S. of Versailles, Mo.</u>					
20c. TIME OF INJURY Hour <u>3:30 p.m.</u> Month <u>9</u> Day <u>9</u> Year <u>57</u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>W. Hwy 5, S. of Versailles</u>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>W. Hwy 5, S. of Versailles</u>			20f. CITY, TOWN, OR LOCATION <u>Versailles, Morgan, Mo.</u>		COUNTY		STATE	
21. I attended the deceased from <u>3:58 p.m. 9-9-57</u> to <u>4:00 p.m. 9-9-57</u> and last saw her alive on <u>9-9-57</u> Death occurred at <u>4 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Lay Lyle, M. D.</u>				22b. ADDRESS <u>Versailles, Mo.</u>		22c. DATE SIGNED <u>9-10-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial H. H. Hargreaves</u>		23b. DATE <u>September 13, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wiley Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colfax Illinois</u>		
24. FUNERAL DIRECTOR <u>John R. Lewis</u> ADDRESS <u>Versailles, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-10-57</u>		26. REGISTRAR'S SIGNATURE <u>J. H. Hargreaves</u>			

SEP 30 1957  
OCT 9 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.....

Licensed Embalmer No.....

P. O. Address.....

**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.