

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 25 1957

32851

STATE FILE NUMBER

Registration District No. 267 Primary Registration District No. 4401 Registrar's No. 159

1. PLACE OF DEATH a. COUNTY <u>Peru</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Peru</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Passola</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Passola</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>Home</u> Length of stay in lb <u>10 yr</u>		d. STREET ADDRESS (If outside, give location) <u>2 mi N.W. Passola</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First Middle <u>DANZLER</u> Last		4. DATE OF DEATH <u>9-13-57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</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>3-1-1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		9b. AGE (In years last birthday) <u>64</u>	9c. IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u> Hours <u></u> Min. <u></u>
10. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Macon Miss</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Nelson Martin</u>		14. MOTHER'S MAIDEN NAME <u>Julia Richardson</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. <u>✓</u>	
17. INDEMNANT <u>Blaine Hantler, 2121 1/2 St, 292</u> Address <u>Passola, MO</u> City, State			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>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 (n) <u>331x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>unfit</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 Hour _____ Month, _____ Day, _____ Year _____ 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 <u>5 Sept 1957</u> to <u>13 Sept 57</u> and last saw <u>her</u> alive on <u>13 Sept 1957</u> Death occurred at <u>2 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F. Tolson</u>		22b. ADDRESS <u>Caruthersville, MO</u>	22c. DATE SIGNED <u>9/17/57</u>
23a. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-16-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Martin</u>	23d. LOCATION (City, town, or county) (State) <u>Macon Miss</u>
24. FUNERAL DIRECTOR <u>J. Smith</u> ADDRESS <u>Hayth - MO</u>	25. DATE RECD. BY LOCAL REG. <u>9-16-57</u>	26. REGISTRAR'S SIGNATURE <u>John W. Lerman</u>	

300
1-56

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON-TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

9-260-57

SEP 23 1957

PLUMBLICK COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *L. A. Hill*.....

Licensed Embalmer No. *26*

P. O. Address *Libbourn*

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.