

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34581

STATE FILE NUMBER

FILED OCT 7 1957

Registration District No. 381 Primary Registration District No. 6178 Registrar's No. 104

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SULLIVAN</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DUNCAN</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>1050</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Length of stay in 1b | | d. STREET ADDRESS (If outside, give location) <u>Duncan Township</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>LURA</u> Middle <u>BOBDA</u> Last <u>FANNING</u> | | | 4. DATE OF DEATH Month <u>OCT.</u> Day <u>1</u> Year <u>1957</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</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>JAN. 1-1890</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | 9c. AGE (In years last birthday) <u>67</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>SULLIVAN COUNTY MO</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>AMON MCKLAREN</u> | |
| 14. MOTHER'S MAIDEN NAME <u>JANE FORD</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>ALLEN FANNING</u> Address <u>BROWNING 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 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 (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</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 _____ 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>9-28-57</u> to <u>10-1-57</u> and last saw her <u>alive</u> on <u>10-1-57</u> Death occurred at <u>9:00 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>V. S. Robinson</u> (Degree or title) <u>D.O.</u> | | 22b. ADDRESS <u>Milan, MO</u> | |
| 22c. DATE SIGNED <u>10-2-57</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | |
| 23b. DATE <u>OCT-3-1957</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>HENRY CEMETERY</u> | |
| 23d. LOCATION (City, town, or county) <u>SULLIVAN</u> | | 23e. (State) <u>MO.</u> | |
| 24. FUNERAL DIRECTOR <u>Schoene's</u> ADDRESS <u>MILAN, MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>10-4-57</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

inh. welfare public vice

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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 *Dwight Schoene*

Licensed Embalmer No. *26*

P. O. Address *Melba, N.J.*

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.