

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 OCT 21 1957

35152

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 89

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Excelsior Springs</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>812 St. Louis Ave</u> Length of stay in lb <u>1 yr</u>		d. STREET ADDRESS (If outside, give location) <u>812 St. Louis Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA AGNES DYKES</u>			4. DATE OF DEATH Month Day Year <u>Sept 26 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>8-19-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) Months Days Hours Min. <u>76</u>
11. BIRTHPLACE (City and state or country) <u>Kearney, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harlow Y. Forman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hall</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>4622F</u>	
17. INFORMANT <u>Mrs. Harry Smart</u> Address <u>812 St. Louis Ave Excelsior Springs 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>Gastric hemorrhage</u> DUE TO (b) <u>Varices, ruptured</u> DUE TO (c) <u>Arteriosclerotic heart disease - decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fr. Rt. hip July 19, '57</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 a. m. p. m. Month, Day, Year			
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>7-19-57</u> to <u>9-26-57</u> and last saw her alive on <u>9-24-57</u> Death occurred at <u>5:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>9-27-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-28-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	23d. LOCATION (City, town, or county) (State) <u>Kearney, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc.</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-57</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>

Excelsior Springs, Missouri (See Halmer's Statement on Reverse Side)



8 1958

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 *Lindell J. Jansman*.....

Licensed Embalmer No. *458*

Enoch Springs
P. O. Address

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