

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35586

STATE LICENSE NUMBER

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 624

300
1-57
4

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor</u>		c. CITY OR TOWN <u>Windsor</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Miller Rest Home</u>		d. STREET ADDRESS <u>Windsor</u>	

3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Heary</u> Last <u>Sole</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1957</u>		
---	--	--	--	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>6-3-1868</u>	9. AGE (In years, In birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>0</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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Circleville, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>John Heary</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine</u>	14. NAME OF HUSBAND OR WIFE <u>Ben Sole</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>None</u>	17. INFORMANT <u>Mrs. Roscoe Wallace Windsor, 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>Acute Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Vascular Accident</u>	<u>1 wk.</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)		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>9:30 p.</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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>Windsor, Mo.</u>	COUNTY <u>Henry</u>	STATE <u>Mo.</u>
---	---	--	---	------------------------	---------------------

21. I attended the deceased from <u>7-15-54</u> to <u>10-23-57</u> and last saw her alive on <u>10-23-57</u> Death occurred at <u>9:30 p.</u> m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Claude M. Thurber M.D.</u> (Degree or title)	22b. ADDRESS <u>Windsor, Mo.</u>	22c. DATE SIGNED <u>10-25-57</u>
---	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-25-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Oak Cemetery</u>	23d. LOCATION (City, town, or county) <u>Windsor, Mo.</u>	(State) <u>Mo.</u>
--	--------------------------------	--	--	-----------------------

24. FUNERAL DIRECTOR <u>Ellis Huston</u>	ADDRESS <u>Windsor, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-30-57</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
---	--------------------------------	---	---

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NOV 20 1957
DEC 3 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 *Clifford Louze*

Licensed Embalmer No. *5014*
P. O. Address *Windsor, Me*

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