

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36657
STATE FILE NUMBER

FILED OCT 29 1957

Registration District No. 210 Primary Registration District No. 5776 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY <u>Mercer</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Putnam</u> <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Unionville</u> ⁰⁵⁶⁰
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <u>6 Weeks</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Bell</u> Last <u>Casady</u>			4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>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>Oct. 23 1868</u>	9. AGE (In years last birthday) <u>88</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 <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Martinsville Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey McDaniel</u>			14. MOTHER'S MAIDEN NAME <u>Malissa Allen</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>A. L. Casady</u> Address <u>Unionville, 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 thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arterio-sclerosis</u>	<u>332X</u> Unknown
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</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. _____	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 October 14, 1957 to October 17, 1957 and last saw ^{her} ~~him~~ alive on October 14, 57
Death occurred at 10:33 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank H. Zehrt MD</u> (Degree or title)	22b. ADDRESS <u>210 W. Main St. Princeton, Mo</u>	22c. DATE SIGNED <u>10-19-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 20 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hartford Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Putnam County Missouri</u>
24. FUNERAL DIRECTOR <u>J. W. Comstock</u> ADDRESS <u>Unionville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-19-57</u>	26. REGISTRAR'S SIGNATURE <u>Paul [unclear]</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Health Service

S. 300 7. 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

MEDICAL CERTIFICATION

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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.....

James W. Comstock

Licensed Embalmer No. *41*

P. O. Address *Unionville*

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.