

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39766
STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 98 Primary Registration District No. 5369 Registrar's No. 9

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>DAVIESS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>DAVIESS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHERIDAN TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>ALTAMONT</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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>SHERIDAN TWP.</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle _____ Last <u>VEGELY</u>			4. DATE OF DEATH Month <u>NOV</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>1-13-1866</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>00</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>FRED WESTPHELING</u>		13b. MOTHER'S MAIDEN NAME <u>MARY McCULLY</u>		14. NAME OF HUSBAND OR WIFE <u>AUGUST VEGELY</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 Name <u>John C Vegely</u> Address <u>Altamont 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>Chronic Myo-Carditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>Senility</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.) <u>4222</u>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>1947</u> to <u>Nov. 23, 1957</u> and last saw her alive on <u>Nov. 20, 1957</u> . Death occurred at <u>12:10</u> A. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Frederick J. Winston, M.D.</u>			22b. ADDRESS <u>Winston, MO.</u>		22c. DATE SIGNED <u>11/26/57</u>
23a. BURIAL, CREMATION, OR DISPOSITION (Specify)	23b. DATE <u>11-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WINSTON</u>		23d. LOCATION (City, town, or county) (State) <u>WINSTON, MO</u>	
24. FUNERAL DIRECTOR <u>Vigil Stamp Winston MO</u>		ADDRESS <u>Winston MO</u>		25. DATE RECD. BY LOCAL REG. <u>6 Dec. 1957</u>	26. REGISTRAR'S SIGNATURE <u>Eugene M Engelbert</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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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 *L. O. Richerson*
Licensed Embalmer No. *3302*
P. O. Address *Gallatin,*

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.