

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41051

STATE FILE NUMBER

FILED NOV 26 1957

Registration District No. 179 Primary Registration District No. 4289 Registrar's No. 129

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hawk Point</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hawk Point</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>In her home</u>			Length of stay in 1b <u>81 yrs</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alberta</u> Middle <u>Augusta</u> Last <u>Witt</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>16</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>July 7, 1876</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Hawk Point, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wilbua Upson</u>				14. MOTHER'S MAIDEN NAME <u>Alma Nichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Ruth Crouch</u>		Address <u>Hawk Point, 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>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Arteriosclerosis ?</u>	
						DUE TO (c) <u>Diabetes Mellitis ?</u>	
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.) <u>260X</u>				
20c. TIME OF INJURY Hour <u>2:10</u> Month <u>5</u> Day <u>15</u> Year <u>1957</u> a. m. <u>2</u> p. m. <u>10</u>							
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>Hawk Point, Missouri</u>		COUNTY STATE	
21. I attended the deceased from <u>5/15/57</u> to <u>8/16/57</u> and last saw her <u>alive</u> on <u>8/16/57</u> Death occurred at <u>2:10</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John T. Sherman</u> (Degree or title)				22b. ADDRESS <u>Hawk Point, Missouri</u>		22c. DATE SIGNED <u>8/17/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/18/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hawk Point Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hawk Point, Mo.</u>			
24. FUNERAL DIRECTOR <u>D. W. M. Boy</u> ADDRESS <u>Troy Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8/22/57</u>		26. REGISTRAR'S SIGNATURE <u>Thomas C. Dunder</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

300  
1-56

NOV 26 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 *D. W. McEoy* .....

Licensed Embalmer No. *350* .....

P. O. Address *Troy Mo* .....

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.