

Death, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41229
STATE FILE NUMBER

FILED NOV 19 1957

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gideon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Gideon</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>Home</u>		Length of stay in lb <u>3 Years</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>NA NOY</u> Middle <u>EMMALINE</u> Last <u>SHARUM</u>			4. DATE OF DEATH Month <u>11</u> Day <u>5</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>10-2-1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
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>None</u>	11. BIRTHPLACE (City and state or country) <u>Miller Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James B. Atwell</u>		13b. MOTHER'S MAIDEN NAME <u>Martha E. Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Otto Sharum</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 Address <u>Flossie Stidham Gideon, Missouri</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>Apoplexy</u>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral thrombosis</u>				331X	
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.) <u>None</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Gideon New Madrid Mo</u>	
21. I attended the deceased from <u>Nov 3 1957</u> to <u>Nov 5 1957</u> and last saw her alive on <u>Nov 5, 1957</u> at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Deceased or title)			22b. ADDRESS <u>Gideon Mo</u>		22c. DATE SIGNED <u>Nov 12/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-8-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Towles Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>5 Mi. So. Doniphan, Mo.</u>
24. FUNERAL DIRECTOR <u>Lloyd Russell</u> ADDRESS <u>[Address]</u>		25. DATE RECD. BY LOCAL REG. <u>11-14-57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs F G Hopkins</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

+560

(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED NOV 15 1957
NEW MADRID CO. HEALTH CENTER

P. J. S.

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 Clayton Russell.....

Licensed Embalmer No. 509-9
P. O. Address Piquette, Pa

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.