

Health,  
& Welfare  
Public  
Service

FILED NOV 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43132  
STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 217

5. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Malta Bend</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>		Length of stay in 1b <u>2 months</u>	d. STREET ADDRESS (If outside, give location) <u>Streets not numbered</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edwin Francis Curry</u>			4. DATE OF DEATH Month Day Year <u>Nov. 20, 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1873</u>
9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	11. BIRTHPLACE (City and state or country) <u>Brown County, Indiana USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Painting</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Westford Curry</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Holtz</u>	14. NAME OF HUSBAND OR WIFE -----
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>Donald R. Snider</u> Address <u>Indianapolis, Ind.</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>Cremation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Renal Failure</u>			<u>1 yr.</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) <u>592x</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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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 <u>Nov 10</u> to <u>Nov 20</u> and last saw him/her alive on <u>Nov 20</u> . Death occurred at <u>12:15 pm.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. Empickel</u> (Degree or title)		22b. ADDRESS <u>Marshall</u>	22c. DATE SIGNED <u>11/21/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-22-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malta Bend Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Malta Bend, Missouri</u>
24. FUNERAL DIRECTOR <u>Campbell-Lewis</u> ADDRESS <u>Marshall, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Cecil G. Reed</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

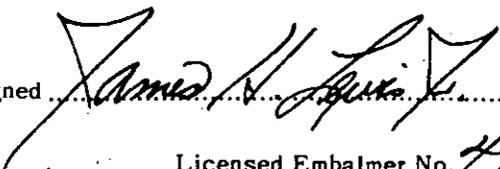
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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  \_\_\_\_\_

Licensed Embalmer No. 4709

P. O. Address Marshall, 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.