

Health,
& Welfare,
S. Public
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v. 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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45096

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 496

1. PLACE OF DEATH a. COUNTY <u>MARION</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>CLARENCE</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>LEVERING HOSP</u>			Length of stay in lb <u>1 yr</u>	d. STREET ADDRESS (If outside, give location) <u>CLARENCE MO</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>MADEL</u> Last <u>STINSON</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>18</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>NOV 11 1911</u>	9. AGE (In years (last birthday)) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	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>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>MO SHELBY COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>JAMES D PAY</u>				14. MOTHER'S MAIDEN NAME <u>MALISSA F CLUTTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WILLARD STINSON GREAT FALL MONTANA</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>Myocardial infarction, acute</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DU TO (b) <u>Chr. myocarditis with decompensation</u> 1 yr.	
						DU TO (c) <u>Hypertensive heart disease</u> 5 yrs.	
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.)				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
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		COUNTY STATE	
21. I attended the deceased from <u>Apr. 1952</u> to <u>Dec. 18, 1957</u> and last saw her alive on <u>12/18/57</u> Death occurred at <u>10:55 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>D. L. Murphy MD</u> (Degree or title)				22b. ADDRESS <u>Claremont Mo</u>		22c. DATE SIGNED <u>12-24-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIA</u>		23b. DATE <u>12-22-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>		
24. FUNERAL DIRECTOR <u>Chas V. Greening</u> Address <u>Claremont Mo</u>			25. DATE RECD. BY LOCAL REG. <u>12-24-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. Em. Lucke W.C. Fisher</u>			

(Licensed Embolmer's Statement on Reverse Side)

RECEIVED DEC 27 1957
MARION CO. HEALTH DEPT.
DATE FILED DEC 27 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 *Charles V. Green*.....

Licensed Embalmer No. *1234*.....

P. O. Address *Clarence*.....

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.