t. Health,
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45507
STATE FILE NUMBER

FILED DEC 31 1957 Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 415

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Flat River. Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Turpin Nurs. Home Length of stay in Ib 1 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Francois
c. CITY OR TOWN Elvins Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First: Mary Middle: Ellen Last: Ashby
4. DATE OF DEATH Month: Dec. Day: 17 Year: 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH Jan 30 1879
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months 10 Days 17 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Farmington Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Issac Cunningham
14. MOTHER'S MAIDEN NAME Mary Gunn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Leland Ashby Address Elvins, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease — Several years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) with myocardial failure — few hours
DUE TO (c) Generalized arterial Sclerosis — Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE 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

21. I attended the deceased from 8/17/49, to 12/17/57 and last saw her alive on 12/1/57
Death occurred at 5:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul L. Jones MD (Degree or title)
22b. ADDRESS 12 Wood Drive Flat River Mo
22c. DATE SIGNED 12/18/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Dec. 19, 1957
23c. NAME OF CEMETERY OR CREMATORY St. Fran. Mem. Park.
23d. LOCATION (City, town, or county) Bonne Terre (State) Mo.

24. FUNERAL DIRECTOR Raymond Calloway and Sons ADDRESS Flat River, Mo
25. DATE RECD. BY LOCAL REG. Dec. 18, 1957
26. REGISTRAR'S SIGNATURE Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

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

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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 emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed R. Caldwell

Licensed Embalmer No. 25

P. O. Address Flat Rw

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.