

pt. Health,  
, & Welfare  
S. Public  
alth Service

FILED DEC 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47085  
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 207

S. 300  
ev. 1-57

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1. PLACE OF DEATH a. COUNTY <u>Yernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Chadwick</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		Length of stay in 1b <u>32 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>unknown</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>MAY</u> Last <u>GUNN</u>			4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>
5. SEX <u>R</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
9. AGE (In years) <u>79</u> Month <u>17</u> Day <u>17</u> Birthdays		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>housewife</u>	11. BIRTHPLACE (City and state or country) <u>Christian Co Mo</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Lorenzo Curry</u>		13b. MOTHER'S MAIDEN NAME <u>Bryphena Hepler</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>State Hospital Records, Nevada Mo.</u> Address
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>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</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)			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>
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>4200</u>	
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>12/31/56</u> to <u>12/19/57</u> and last saw her/him alive on <u>12/19/57</u> Death occurred at <u>3:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>George Esker, M.D.</u> (Dr, nurse or title)		22b. ADDRESS <u>State Hospital No 3</u>	22c. DATE SIGNED <u>12/19/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>state Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>
24. FUNERAL DIRECTOR <u>Ferry Funeral Home Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-21-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</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 *L. Douglas Perry* .....

Licensed Embalmer No. *4960* .....

P. O. Address *Nevada, M* .....

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.