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Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part 1 must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2099

FILED FEB 4 1958

Registration District No. 234 Primary Registration District No. 5815 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY: Morgan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hawcreek Twp. Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): one mile west Stover Length of stay in Ib: 1 da.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Morgan
c. CITY OR TOWN: Hawcreek Twp. Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): one mile west Stover Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Mazel Marie Middle: Kreglinger Last:
4. DATE OF DEATH: Month Jan. Day 25 Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 16, 1911
9. AGE (In years last birthday): 46
IF UNDER 1 YEAR: Months 9 Days 9 Hours Min.
IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and state or country): Morgan County Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Orv Marriott
14. MOTHER'S MAIDEN NAME: Amanda Branch
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: Paul Kreglinger Address: Stover, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxic Medullary Paralysis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pulmonary Metastasis
DUE TO (c) Carcinoma of Uterus.
INTERVAL BETWEEN ONSET AND DEATH: 3 Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Carcinomatosis 174X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 Oct 1957 to 1/25/1958 and last saw her ~~him~~ alive on 1/25/1958.
Death occurred at 10:P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Edward A. Steffa (Degree or Title) D.O.
22b. ADDRESS: Stover, Mo
22c. DATE SIGNED: 1/27/58.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 29, 1958
23c. NAME OF CEMETERY OR CREMATORY: Stover Cemetery
23d. LOCATION (City, town, or county) (State): Stover Missouri

24. FUNERAL DIRECTOR: S. L. Stevenson ADDRESS: Stover Mo.
25. DATE REC'D BY LOCAL REG.: Feb. 1 - 1958
26. REGISTRAR'S SIGNATURE: Wm L. Reppenger

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed J. L. Stevinson

Licensed Embalmer No. 407

P. O. Address Stover,

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