

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012898

STATE FILE NUMBER

FILED APR 2 1958

Registration District No. 340

Primary Registration District No. 6151

Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Catron</u>		c. CITY OR TOWN <u>Catron</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R. 1 Elk Twp.</u>		d. STREET ADDRESS (If outside, give location) <u>R. 1 Elk Twp.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>NMI</u> Last <u>Morris</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1902</u>
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>Coila, Miss.</u>
13a. FATHER'S NAME <u>Andrew Jackson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</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>XXXXXXXXXX</u>	17. INFORMANT <u>Josephine Keys Youngstown, Ohio.</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>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
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.) <u>2</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 _____, to _____ and last saw her ^{her} alive on _____ Death occurred at <u>4 a.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. H. Wilkins</u> (Degree or title) <u>Counselor</u>		22b. ADDRESS <u>Dexter, Mo.</u>	22c. DATE SIGNED <u>3-10-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3-11-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dexter cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dexter, Mo.</u>
24. FUNERAL DIRECTOR <u>Watkins & Sons</u>	ADDRESS <u>Dexter, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3/24/58</u>	26. REGISTRAR'S SIGNATURE <u>Velma V. Jenkins</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Earl Matthews*

Licensed Embalmer No. *4964*
P. O. Address *Septon, 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.