

FILED MAR 18 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012980  
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 32

300  
-57

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1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stone</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Galena</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #3</b>		Length of stay in 1b <b>5-15-52 to 3-5-58</b>	d. STREET ADDRESS (If outside, give location) <b>Unknown</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Lizzie</b> Middle <b>Cloud</b> Last <b>Cloud</b>			4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-1-1878</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
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13a. FATHER'S NAME <b>John Teague</b>	13b. MOTHER'S MAIDEN NAME <b>Emey Biler</b>	14. NAME OF HUSBAND OR WIFE <b>Widowed</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Admission Papers</b> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vessel Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Atheromatous Sclerosis</b>		<b>Years</b>
	DUE TO (c) <b>Senile Dementia</b>		<b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senile Dementia</b>		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.) <b>4201</b>
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20c. TIME OF INJURY Hour <b>2</b> Month, Day, Year
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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 <b>Stone County, Missouri</b>
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21. I attended the deceased from **April 25, 1955** to **March 5, 1958** and last saw her alive on **March 5, 1958**  
Death occurred at **9:30 A.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>E. Williams, M.D.</b>	22b. ADDRESS <b>State Hospital Number Three Nevada, Missouri</b>	22c. DATE SIGNED <b>3-5-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 9, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tonce Leon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Stone County, Missouri</b>
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24. FUNERAL DIRECTOR <b>Ferry Funeral Home</b>	ADDRESS <b>Nevada, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-10-1958</b>	26. REGISTRAR'S SIGNATURE <b>Arma E. Ferry</b>
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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 *L. Douglas Ferry* .....

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

P. O. Address *Hamada, Md.* .....

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.