

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013042
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 124

| | | | | | |
|--|-------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ADAIR | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ADAIR | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKSVILLE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN BRASHEAR | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LAUGHLIN Hosp. | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First HAZEL Middle MAE Last CHURCH | | | 4. DATE OF DEATH Month 4 Day 14 Year 1958 | | |
| 5. SEX F | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 25, 1913 | 9. AGE (In years last birthday) 44 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Wilcoxville, Mo. | |
| 13. FATHER'S NAME VIRGIL ERWIN | | | 14. MOTHER'S MAIDEN NAME BERTHA MAE CLARKSON | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address JEROME CHURCH BRASHEAR, Mo | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO (b) Pancarditis DUE TO (c) Lobar pneumonia & anaphylactic reaction | | | | | INTERVAL BETWEEN ONSET AND DEATH: 20 min. 2 days? 7 days |
| 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"/> 2 | | |
| 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.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 April 9, 1958 to April 14, 1958 and last saw her alive on April 14, 1958 Death occurred at 5:25 P. M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Death or title) Jack Austin, P.O. | | | 22b. ADDRESS Kirksville, Mo. | | 22c. DATE SIGNED 4-15-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) APR. 17, 1958 | | 23c. NAME OF CEMETERY OR CREMATORY SABBATH HOME | | 23d. LOCATION (City, town, or county) (State) ADAIR Co. Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS MARGARET Easley BRASHEAR, Mo. | | 25. DATE RECD. BY LOCAL REG. 4-17-1958 | | 26. REGISTRAR'S SIGNATURE Doris W. Ratliff | |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Every coroner, chief, or other person who has authority to issue a death certificate must see that the cause of death is clearly stated and that the cause of death is not a symptom of another disease. 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 em
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Richard B. Kelly*.....

Licensed Embalmer No. *44*

P. O. Address *Elia, 7*

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.