Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-018790

STATE FILE NUMBER

FILED JUN 13 1958 Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 79

1. PLACE OF DEATH a. COUNTY JEFFERSON	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JEFFERSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) CRYSTAL CITY — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN CRYSTAL CITY 0501 0 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) TAYLOR AVE. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 417 TAYLOR AVE. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JUDITH Middle MAY Last PRUNEAU		4. DATE OF DEATH Month 6-4-58 Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH SEPT. 7, 1875
9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (City and state or country) FESTUS, MISSOURI 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JOHN H. KENNER	13b. MOTHER'S MAIDEN NAME MARTHA BLANKENSHIP	14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address ERNEST PRUNEAU CRYSTAL CITY, 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) Cerebral hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis

DUE TO (c) 331X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 March, 1955, to Dec. 1957 and last saw her/him alive on Dec 28, 1957

Death occurred at 8:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bertha Bolgwon	22b. ADDRESS Festus, Mo	22c. DATE SIGNED 6/4/58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6-7-58	23c. NAME OF CEMETERY OR CREMATORY ROSELAWN MEMORIAL
23d. LOCATION (City, town, or county) (State) CRYSTAL CITY, MO.		
24. FUNERAL DIRECTOR ADDRESS GENTRY R. POLITTE CRYSTAL CITY, MO.	25. DATE RECD. BY LOCAL REG. 6-4-58	26. REGISTRAR'S SIGNATURE Jesse G. Rigdon

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI
DATE RECEIVED
JUN 11 1958
JUN 19 1958

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 .....

Licensed Embalmer No. 348

P. O. Address .....

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.