

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018880

STATE FILE NUMBER

Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 39

0540
1
MAY 19 1958

Health,
Welfare
Public
Service

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <i>Pulaski</i>				2. USUAL RESIDENCE (Where deceased lived. If Institution Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Pulaski</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Higginsville</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Higginsville</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb <i>1 mi. North</i>		d. STREET ADDRESS (If outside, give location) <i>1 mi. North</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Elizabeth Foster</i>				4. DATE OF DEATH Month <i>May</i> Day <i>6</i> Year <i>1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 21, 1894</i>		9. AGE (In years, ^{or} UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months <i>83</i> Days <i>8</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stenographer</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Warrensburg, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James Cameron</i>				14. MOTHER'S MAIDEN NAME <i>Malvina McDaniel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Mrs. Carl Hader, Higginsville Mo.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Arterio Sclerotic Cardio Vascular Disease</i>				Years	
		DUE TO (c)					
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? <i>2</i> 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.) <i>4221</i>				
20c. TIME OF INJURY Hour <i>6:50</i> Month, Day, Year a. m. p. m.							
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		COUNTY STATE	
21. I attended the deceased from <i>1950</i> to <i>5/6/58</i> and last saw her ^{her} _{him} alive on <i>5/6/58</i> Death occurred at <i>6:50</i> a. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Wm B. Bailey, M.D.</i>				22b. ADDRESS <i>Higginsville, Mo.</i>		22c. DATE SIGNED <i>5/8/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 8, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>City</i>		23d. LOCATION (City, town, or county) (State) <i>Higginsville, Mo.</i>		
24. FUNERAL DIRECTOR <i>Wiggins-Pinkley-Higginsville Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>5-14-58</i>		26. REGISTRAR'S SIGNATURE <i>Marie D Bailey</i>		

(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 embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Fred Rickhof*.....

Licensed Embalmer No. *420*

P. O. Address *Higginsville*

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.