

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028942
STATE FILE NUMBER

FILED SEP 8 1958

Registration District No. 139

Primary Registration District No. 4221

Registrar's No. 59

4
300
1-57

1. PLACE OF DEATH a. COUNTY HOLT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MOUND CITY		c. CITY OR TOWN MOUND CITY	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION DUNCAN NUR. Hm.		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b 1 WEEK		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First RUBY Middle PEARL Last DRIVER			4. DATE OF DEATH Month Aug Day 30 Year 1958		
5. SEX FEMALE	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 JAN. 27, 1889	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR 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 in the home		11. BIRTHPLACE (City and state or country) MOUND CITY, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME JOHN H. CRIST		13b. MOTHER'S MAIDEN NAME EMMA F. GLICK	
14. NAME OF HUSBAND OR WIFE CASPER M. DRIVER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DEAN DRIVER - Maryville, 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) Coronary Occlusion DUE TO (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 days " unknown	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Adeno Carcinoma of the bladder 4300H		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.)	
20c. TIME OF INJURY Hour 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 July 1 1952 to Aug 30, 1958 and last saw her alive on Aug 30, 1958 Death occurred at 8:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) James Frank Sweeney M.D.	22b. ADDRESS Creysa, Missouri	22c. DATE SIGNED 9/2/58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-2-1958	23c. NAME OF CEMETERY OR CREMATORY Mount Hope	23d. LOCATION (City, town, or county) (State) MOUND CITY, Mo.
24. FUNERAL DIRECTOR James H. Crawford Mound City, Mo.	25. DATE RECD. BY LOCAL REG. 9-2-1958	26. REGISTRAR'S SIGNATURE James H. Crawford	

(License Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms with 58 listed. All diseases in Part I must be causally related.

SEP 0 1958

SEP 18 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 *James H Crawford* Licensed Embalmer No. *4796* P. O. Address *T. Round City*

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.