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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035164
STATE FILE NUMBER

FILED SEP 30 1958

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY: Saline	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo. b. COUNTY: Saline
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Slater — Inside Limits: Yes X No ☐	c. CITY OR TOWN: Slater 0971 0 — Inside Limits: Yes ☐ X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): none — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Hattie Middle: ✓ Last: Ware

4. DATE OF DEATH: Month: Sept. Day: 24 Year: 1958

5. SEX: female 3

6. COLOR OR RACE: negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: about 1873

9. AGE (In years last birthday): 85 plus — 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): at home

10b. KIND OF BUSINESS OR INDUSTRY: no

11. BIRTHPLACE (City and state or country): Saline Co. Mo.

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Novella Wright, Address: Slater, 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): Generalized Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Gangrene left foot
DUE TO (c): 4501

INTERVAL BETWEEN ONSET AND DEATH: 3 months

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 ☐ 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 July 1953, to Sept 58 and last saw her/him alive on 9-24-58
Death occurred at Slater Mo 9-30-58 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dr Nelson Swartz

22b. ADDRESS: 313 N. Main

22c. DATE SIGNED: 9-26-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Sept. 27 '58

23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery

23d. LOCATION (City, town, or county) (State): Slater, Mo.

24. FUNERAL DIRECTOR ADDRESS: Hill Brothers Slater Mo

25. DATE RECD. BY LOCAL REG.: 9/27-'58

26. REGISTRAR'S SIGNATURE: Mrs. Earl C. Metz

(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 em

by me, or ~~by~~ ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Sam M Hill

Licensed Embalmer No. 12

P. O. Address Slater

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.