

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039349

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 161

S. 300  
r. 1-57

1. PLACE OF DEATH a. COUNTY <b>Cooper</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cooper</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Boonville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Overton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Length of stay in 1b <b>1 Week</b>	d. STREET ADDRESS (If outside, give location) -----		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Baze</b> Last <b>Newell</b>			4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1877</b>	9. AGE (In years, (month birthday)) <b>81</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Clarksburg, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Beverly Baze</b>		13b. MOTHER'S MAIDEN NAME <b>Lucy Jane Bailey</b>		14. NAME OF HUSBAND OR WIFE <b>John E. Newell.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address <b>Mrs. Earl Fischer, Overton Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio-sclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
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 <b>Jan 1952</b> to <b>Dec 5-58</b> and last saw her alive on <b>Dec 4-58</b> Death occurred at <b>1:30 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Dr. Decker</b>			22b. ADDRESS <b>Boonville Mo</b>		22c. DATE SIGNED <b>12/6/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 7, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove</b>		23d. LOCATION (City, town, or county) (State) <b>Boonville, Missouri.</b>
24. FUNERAL DIRECTOR <b>Goodman &amp; Boller,</b>		ADDRESS <b>Boonville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/6/58</b>	26. REGISTRAR'S SIGNATURE <b>Dr. Hooper</b>

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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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 *William W. Wood* .....

Licensed Embalmer No. 4539 .....

P. O. Address Boonville, Mo. .....

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.