Health, Welfare Public Service

300
1-56

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043660
STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 098 Primary Registration District No. ..... Registrar's No. 125

1. PLACE OF DEATH
a. COUNTY Daviess
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jamesport — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Daviess
c. CITY OR TOWN Jamesport — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Mina Middle: Scott Last:
4. DATE OF DEATH Month: Dec Day: 10 Year: 1958
5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: Jan 28 1874
9. AGE (In years last birthday): 85 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Jameson-Mo
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Berry
14. MOTHER'S MAIDEN NAME: Elizabeth Redinger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Ruby Scott Address: Jamesport-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) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — 18 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4 20 1
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 Dec 10-58 to Dec 10 58 and last saw her alive on Dec 10 58
Death occurred at 4:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H B Bailey (Degree or title) D.O. — 22b. ADDRESS Jamesport Mo — 22c. DATE SIGNED 12-10-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: 12 Dec 58 — 23c. NAME OF CEMETERY OR CREMATORY: Masonic. — 23d. LOCATION (City, town, or county) (State): Jamesport - Missouri

24. FUNERAL DIRECTOR: O.L. Roberson — ADDRESS: Jamesport, Mo — 25. DATE RECD. BY LOCAL REG.: 12-29-58 — 26. REGISTRAR'S SIGNATURE: Virgil M Engelhart

(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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

8 1 0

JAN 9 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en
by me, or by Harvey Allen Robenson, Student Embalmer No. 56
working under my personal supervision.

Student Harvey A. Robenson
Signature of Student Embalmer

Signed R. L. Robenson

Licensed Embalmer No. 32

P. O. Address Jamestown, N

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.