

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-047210  
STATE FILE NUMBER

FILED JAN 16 1959 Registration District No. 280 Primary Registration District No. 4431 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <b>PLATTE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOWARD</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>PARKVILLE</b> <i>Platte</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>NEW FRANKLIN</b> <i>345</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R.R. 2</b>		Length of stay in lb <b>4 days</b>	d. STREET ADDRESS (If outside, give location) <b>201 S. HOWARD</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>MAY</b> Last <b>TREASTER</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>27</b> Year <b>1958</b>			
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 6, 1891</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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>SELF</b>	11. BIRTHPLACE (City and state or country) <b>MARION COUNTY, MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>CHARLES LOCKE</b>	13b. MOTHER'S MAIDEN NAME <b>ANNIE ROGERS</b>	14. NAME OF HUSBAND OR WIFE <b>CHARLES R. TREASTER</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>487-24-8333</b>	17. INFORMANT <b>CHARLES R. TREASTER</b> Address <b>NEW FRANKLIN</b>
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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>Pulmonary Edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cardiac Failure</b>	
	DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>	
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 <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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from <b>12-27-58</b> to <b>12-27-58</b> and last saw her alive on _____ Death occurred at <b>240 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Marion S. Hayden M.D.</i> (Degree or title)	22b. ADDRESS <b>Route 1 Box 19 Goodland Mo.</b>	22c. DATE SIGNED <b>12-27-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>DEC. 27 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>NEW FRANKLIN, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>MARKLAND-HALL - NEW FRANKLIN, MO</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Dec 27, 19 58</b>	26. REGISTRAR'S SIGNATURE <i>B. plus Rollins</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

0561 6 2 1959



STATEMENT BY LICENSED EMBALMER

JAN 19 1959

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 Tom D. Markland .....

Licensed Embalmer No. 4592 .....  
P. O. Address New Franklin .....

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.