

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

000447

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 16

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fulton</b> <b>01430</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>Callaway Hosp</b>		Length of stay in 1b <b>2 Weeks</b>	d. STREET ADDRESS (If outside, give location) <b>Seminole Court</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Myra</b> Middle <b>S.</b> Last <b>Deaver</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>16</b> Year <b>1959</b>	
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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"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov, 12, 1891</b>	9. AGE (In years birth day) <b>67</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pianist at Mo. School for the Deaf</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Callaway County, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>James Buckner Sharp</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Lawrence</b>	14. NAME OF HUSBAND OR WIFE <b>James Ellis Deaver</b>
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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. <b>492-36-9098</b>	17. INFORMANT Address <b>Sally Jones Chico, California</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>acute intestinal obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Some 11/7/59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Post-op. adhesions - Ventral Hernia.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Traumatic Pulmonary Embolus 5613</b>		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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	

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 **1/2/59**, to **1/16/59** and last saw her alive on **1/16/59**  
Death occurred at **about 7:30 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Nancy Deaver M.D.</b>	22b. ADDRESS <b>Fulton Mo</b>	22c. DATE SIGNED <b>1/17/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan-18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fulton Mo</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Wallace Funeral Home, Fulton Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Jan-17-1959</b>	26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 27 1959

JAN 22 1959

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 *Hector R. Masure*

Licensed Embalmer No. *4996*

P. O. Address *Fulton, Md*

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.