

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008712
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 64 Primary Registration District No. 5245 Registrar's No. 23

300
-57

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1. PLACE OF DEATH a. COUNTY <u>Chariton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Chariton</u>	
b. CITY OR TOWN <u>Keytesville Twp.</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Brunswick Mo.</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chariton Co. Rest</u>	Length of stay in lb <u>Home 3-Mths.</u>	d. STREET ADDRESS <u>Brunswick Twp.</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Annie</u>	Middle <u>Elizabeth</u>	Last <u>Haskins</u>	4. DATE OF DEATH Month <u>March</u> Day <u>30th</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18th, 1875</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Keytesville Twp. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Venable</u>	13b. MOTHER'S MAIDEN NAME <u>Roxana Ewing</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Allen Haskins</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Dorothy Wade</u> Address <u>K.C., Mo.</u>
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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) <u>Congested Heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Senility</u>	
	DUE TO (c) <u>Mental patient for two years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>309X</u>		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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Feb. 5th - 59</u> to <u>March. 30th 59</u> and last saw her alive on <u>March. 30th 59</u> Death occurred at <u>3:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. L. Lepore</u> (Degree or title) <u>2</u>	22b. ADDRESS <u>Brunswick MO</u>	22c. DATE SIGNED <u>April 2, 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 1st 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dalton, Mo.</u>
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24. FUNERAL DIRECTOR <u>W. H. Bennett</u> ADDRESS <u>Keytesville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4/10/59</u>	26. REGISTRAR'S SIGNATURE <u>J. L. Lepore</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *W. D. Garrett*

Licensed Embalmer No. *3046*

P. O. Address *714 N. 1st St. S. Okla City*

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.