

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008901

STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 99 Primary Registration District No. _____ Registrar's No. 16

300
-57

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clarksdale		c. CITY OR TOWN Clarksdale ^{0 320}	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home in town		d. STREET ADDRESS (If outside, give location) Home	
3. NAME OF DECEASED (Type or print) Saron		4. DATE OF DEATH Month 3 Day 16 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Mo
13a. FATHER'S NAME Edward Gibbons		13b. MOTHER'S MAIDEN NAME Elizabeth Ridgeway	14. NAME OF HUSBAND OR WIFE Clarence Thornton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Clarence Thornton Address Clarksdale Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE Acute Myocardites with arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 12 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) Gastric ulcer with malnutrition 4.2.2.1			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 _____ 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
21. I attended the deceased from <u>1943</u> to <u>3/16/59</u> and last saw her alive on <u>3/16/59</u> Death occurred at <u>4:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Zac K. Barnes (Degree or title) 2		22b. ADDRESS Beug City Mo	22c. DATE SIGNED 3/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-16-59	23c. NAME OF CEMETERY OR CREMATORY Thornton	23d. LOCATION (City, town, or county) (State) Clarksdale Mo
24. FUNERAL DIRECTOR Shubert ADDRESS Haysville Mo		25. DATE RECD. BY LOCAL REG. 2-2-59	26. REGISTRAR'S SIGNATURE Nascoe Davidson

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

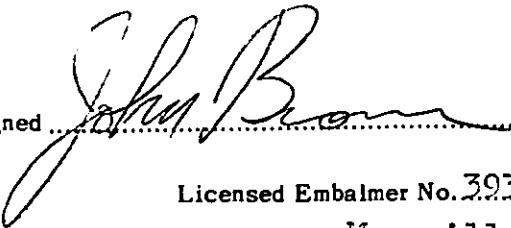
All diseases in Part I must be causally related.

VS
APR 6
1960

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 

Licensed Embalmer No. 3933.....

P. O. Address Waynesville No.....

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.