

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012117

STATE FILE NUMBER

FILED MAR 25 1958

Registration District No. 366 Primary Registration District No. 6238 Registrar's No. 31

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Belgrade News</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>1100</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>6 mi W. Belgrade</u>		d. STREET ADDRESS (If outside, give location) <u>6 mi W. Belgrade</u>	
Length of stay in lb <u>30 yrs</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Emma</u> Last <u>Phelps</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1959</u>
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>April 9 1887</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Month <u>11</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. mail carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Sherman Barber</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Hemick</u>		14. NAME OF HUSBAND OR WIFE <u>Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Lola Elliott Peters Mo.</u>		Address <u></u>	
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>Medullary Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac mural Thrombus Formation and Thrombotic myocardial Infarction.</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>42E1</u>
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.)		
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 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>6-16-58</u> to <u>3-22-59</u> and last saw her alive on <u>Sunday March 22, 1959</u> Death occurred at <u>11:20 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Sara D. Spinks DO<sup>2</sup></u>		22b. ADDRESS <u>211E. High Street, Potosi, Mo</u>	
22c. DATE SIGNED <u>3/23/59</u>		23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>3-25-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Caledonia M.E. Cem. Washington Co. Mo.</u>	
23d. LOCATION (City, town, or county) (State) <u>Washington Co. Mo.</u>		24. FUNERAL DIRECTOR <u>Ms. Luther Spinks Potosi Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>3/24/59</u>		26. REGISTRAR'S SIGNATURE <u>N. Brut Rudall</u>	

(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

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 *Murphy L. Sparks* .....

Licensed Embalmer No. *4236* .....  
P. O. Address *F. LaRimer* .....

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.