

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014008

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 181 Primary Registration District No. 4293 Registrar's No. 15

300
1-57

1. PLACE OF DEATH a. COUNTY LINCOLN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LINCOLN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELSBERRY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ELSBERRY
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 514 N. THIRD		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 514 N. THIRD
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ANNIE FRANCES FERRY			4. DATE OF DEATH Month Day Year MAY 2, 1959		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 17, 1868		9. AGE (In years last birthday) 91

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (City and state or country) ELSBERY, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME SAMUEL ROBINSON	13b. MOTHER'S MAIDEN NAME LYDIA ELSBERRY	14. NAME OF HUSBAND OR WIFE CLARENCE W. FERRY
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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) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT LEIGHTON FERRY	Address ELSBERY, Mo.
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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) CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
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)		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.) 332X
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <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 Death occurred at 9/20/89 to 5/2/89 and last saw her alive on 4/22/89 27:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) M.D.	22b. ADDRESS ELSBERY, MO	22c. DATE SIGNED 5/3/89

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 4, 1959	23c. NAME OF CEMETERY OR CREMATORY CITY	23d. LOCATION (City, town, or county) (State) ELSBERY, Mo.
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24. FUNERAL DIRECTOR O. C. RICKS	ADDRESS ELSBERY, Mo.	25. DATE RECD. BY LOCAL REG. 5/9/1959	26. REGISTRAR'S SIGNATURE Mrs. Clarence Kinty
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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 *J. Galambos*

Licensed Embalmer No. *4012*

P. O. Address *Edsberry, Mo.*

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.