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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-014086
STATE FILE NUMBER

FILED APR 1 1959 Registration District No. 200 Primary Registration District No. Registrar's No. 66

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|---|---|
| 1. PLACE OF DEATH a. COUNTY: Macon | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: Macon |
| b. CITY OR TOWN: Ethel — Inside Limits: Yes [X] No [ ] | c. CITY OR TOWN: Ethel 6610 — Inside Limits: Yes [X] No [ ] |
| c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in Ib: 14 yrs. | d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes [ ] No [X] |

3. NAME OF DECEASED (Type or print): First: Ethel Middle: Shady Last: Allard

4. DATE OF DEATH: Month Day Year: March 27, 1959

5. SEX: Female 1

6. COLOR OR RACE: White 2

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March 8, 1883

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

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): Oskaloosa, Iowa 1

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Daniel Hull

13b. MOTHER'S MAIDEN NAME: Effie Glascock

14. NAME OF HUSBAND OR WIFE: deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Howard Allard Address: Ethel, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Coronary Occlusion

DUE TO (c): Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 10-18-56, to 3-27-59 and last saw her/him alive on 3-24-59. Death occurred at 5:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title): MD 2

22b. ADDRESS: Kirksville, Missouri

22c. DATE SIGNED: 3-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-30-59

23c. NAME OF CEMETERY OR CREMATORY: Masonic Cemetery

23d. LOCATION (City, town, or county) (State): Bucklin, Missouri

24. FUNERAL DIRECTOR ADDRESS: Larson Funeral Service Bucklin, Mo.

25. DATE RECD. BY LOCAL REG.: 3-30-59

26. REGISTRAR'S SIGNATURE: Ruth McNeely

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 C. A. Larson

Licensed Embalmer No. 4037

P. O. Address Bucklin, 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.