

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020579
STATE FILE NUMBER

FILED JUL 7 1958 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 183

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cleburne</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #1</u>		Length of stay in lb <u>6 years 12 days</u>	d. STREET ADDRESS (If outside, give location) <u>514 E 25th Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HELDA</u> Middle <u>MAY</u> Last <u>DEMAND</u>			4. DATE OF DEATH Month <u>July</u> Day <u>1st</u> Year <u>1959</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6-1881</u>	9. AGE (In years last birthday) <u>78</u>	FUNDER 1 YEAR Months <u>0</u> Days <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>None</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Nathan Wilson</u>	13b. MOTHER'S MAIDEN NAME <u>Angelina Brown</u>	14. NAME OF HUSBAND OR WIFE <u>Vernon Demand</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)	16. SOCIAL SECURITY NO. <u>OK</u>	17. INFORMANT <u>Vernon Demand</u> Address <u>Sedalia 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>Acute cholangitis</u> <u>Cholecholelithiasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>584X</u>
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20c. TIME OF INJURY Hour _____ 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 <u>Sedalia</u> COUNTY _____ STATE _____
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21. I attended the deceased from <u>June 18-1954</u> to <u>July 1st 1959</u> and last saw her alive on <u>July 1st 1959</u> Death occurred at <u>6 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Fred P. Handler M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hosp. #1 Fulton Mo.</u>	22c. DATE SIGNED <u>7-1-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OK</u>	23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
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24. FUNERAL DIRECTOR <u>D W Beckhart</u> ADDRESS <u>Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>July 1-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Health Service
S. 300 1-57
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

+26°
C

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 Clifford George

Licensed Embalmer No. 5014

P. O. Address Bedalia, 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.