

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 14 1959

59-025720

Registration District No. 139 Primary Registration District No. 4249 Registrar's No. 51

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEFF</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HILLS BORO</u>		Length of stay in 1b <u>3 months</u>		c. CITY OR TOWN <u>DE SOTO</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>Main St</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>STEWART ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE MARGY WALL</u>				4. DATE OF DEATH Month Day Year <u>July 17 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"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>WASHINGTON Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>JOHN EDGAR BAKER</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH JANE SANDERS</u>			14. NAME OF HUSBAND OR WIFE <u>deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>SIDNEY WALL DE SOTO, MO.</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>Cerebral hemorrhage.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>June 24, 59</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Gen. arterio-sclerosis</u>		DUE TO (c)		years <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 Month, Day, Year 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.) <u>no</u>		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>Jan 12, 1953</u> to <u>July 17, 1959</u> and last saw her <u>him</u> alive on <u>July 15, 1959</u> Death occurred at <u>5:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Norv. J. J. J. M.D.</u>				22b. ADDRESS <u>De Soto, Mo.</u>		22c. DATE SIGNED <u>July 20, 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		23d. LOCATION (City, town, or county) <u>DE SOTO</u>		(State) <u>MO</u>		
24. FUNERAL DIRECTOR <u>MAHN Funeral Home</u>		ADDRESS <u>De Soto Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Oleta Burdick, Reg</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 13 1969

Karl V McKinstry, M.D.  
DeSoto, Missouri

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lerald J. Mahan

Licensed Embalmer No. 4975

P. O. Address De Soto, 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.