

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 25 1959

59-029624

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 123 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington township		Length of stay in 1b 24 hrs.	c. CITY OR TOWN Verona
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 14mi. S. of Lebanon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route #2
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Tena Middle Conway Last _____			4. DATE OF DEATH Month Aug. Day 18, Year 1959		
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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 3-8-1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY housework	11. BIRTHPLACE (City and state or country) Springfield, Mo. U.S.A.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Albert Uddenburg	13b. MOTHER'S MAIDEN NAME Rhoada Pilkerton	14. NAME OF HUSBAND OR WIFE deceased
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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 Address Harold Coffman, Lebanon, 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) <i>Pulmonary Embolism</i> DUE TO (b) <i>Hamstring, hepatitis legs</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH 2 days
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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
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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 date of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY	Hour _____ a.m. _____ p.m.	Month, Day, Year	
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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
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21. I attended the deceased from 1/5/59 to 8/18/59 and last saw ^{her} _{him} alive on 8/11/59
 Death occurred at 9:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>M. D. Messer</i>	22b. ADDRESS <i>Verona Mo</i>	22c. DATE SIGNED <i>8/18/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 8-18-59	23c. NAME OF CEMETERY OR CREMATORY Spring River Cemetery	23d. LOCATION (City, town, or county) (State) Verona, Mo. Lawrence Co. Mo.
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24. FUNERAL DIRECTOR ADDRESS <i>H. J. Shabel, Lebanon, Mo.</i>	25. DATE RECD. BY LOCAL REG. 8-18-1958	26. REGISTRAR'S SIGNATURE <i>Hella L. Hlay</i>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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 me _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H D Fossett

Licensed Embalmer No. 220
P. O. Address Mt Vernon

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.

AUG 27 1959