

FILED VS FEB 1 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

=60-002505  
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 26

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>0644 Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hadley TWP. 81208</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth 2</u>		Length of stay in 1b <u>37 days</u>	d. STREET ADDRESS (If outside, give location) <u>6 Miles E. of Barry</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sylvia</u> Middle <u>Dusenbery</u> Last <u>Dusenbery</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>1960.</u>
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>Apr. 17, 1887</u>
9. AGE (In years birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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>on farm</u>	11. BIRTHPLACE (City and state or country) <u>Clinton, Illinois.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>Thomas Spencer</u>	
13b. MOTHER'S MAIDEN NAME <u>Bell Baker</u>		14. NAME OF HUSBAND OR <del>SEX</del> <u>Fred Dusenbery</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 <u>Fred Dusenbery</u> Address <u>New Salem, Ill.</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) _____ DUE TO (b) <u>Myocardial failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>5 yrs</u> 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 <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 <u>Dec/20/59</u> to <u>Jan/25/60</u> and last saw her/him alive on <u>Jan/24/60</u> Death occurred at <u>6:15 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>[Address]</u>	22c. DATE SIGNED <u>1/25/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Jan. 27, 1960.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Side</u>	23d. LOCATION (City, town, or county) (State) <u>Pittsfield, Illinois.</u>
24. FUNERAL DIRECTOR <u>V. Crawford Smith</u> ADDRESS <u>Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>1-25-1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

1-0

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 *W. Crawford Smith* .....

Licensed Embalmer No. *3814* .....

P. O. Address .....

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.