

Health, Welfare Public Service

300 1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. No standard nomenclature in item 18.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **36815**
REGISTRATION DISTRICT NO. **360** PRIMARY REGISTRATION DISTRICT NO. **6225** REGISTRAR'S NO. **103**

FILED OCT 30 1956

1. PLACE OF DEATH <i>State Hosp no 9</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <i>Vernon</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	a. STATE <i>Missouri</i> b. COUNTY <i>Cass</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Washington</i>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Washington</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Wood Hall Hosp</i> Length of stay in lb <i>6-8-12</i>		d. STREET ADDRESS (If outside, give location) <i>Union</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Era</i> Middle <i>Alice</i> Last <i>Park</i>			4. DATE OF DEATH Month <i>10</i> Day <i>22</i> Year <i>1956</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-4-1876</i>	9. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>3</i> Days <i>18</i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>L</i>	11. BIRTHPLACE (City and state or country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <i>Adm. Papers</i> Address <i></i>		

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>Coronary Vessel Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Yes</i> <i>Yes</i>
DUE TO (b) <i>atherosclerosis</i>		
DUE TO (c) <i></i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senile Dementia</i>		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.) <i>420-1</i>	
20c. TIME OF INJURY Hour <i></i> Month <i></i> Day <i></i> Year <i></i> a. m. <i></i> p. m. <i></i>		

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.) <i></i>	20f. CITY, TOWN, OR LOCATION <i></i> COUNTY <i></i> STATE <i></i>
21. I attended the deceased from <i>11-24-55</i> to <i>10-22-56</i> and last saw <i>her</i> alive on <i>10-22-56</i> . Death occurred at <i>6:30</i> <i>p</i> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <i>E. Allmendinger MD</i> (Degree or title)	22b. ADDRESS <i>Moada Mo</i>	22c. DATE SIGNED <i>10-22-56</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-25-56</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washburn Prairie</i>	23d. LOCATION (City, town, or county) (State) <i>Barry County Missouri</i>
24. FUNERAL DIRECTOR <i>Paul N. Henbest</i> ADDRESS <i>Cassville, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>10-26-1956</i>	26. REGISTRAR'S SIGNATURE <i>Anna E. Perry</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Margaret C. Herbert*

Licensed Embalmer No. *43*

P. O. Address *Casson*

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.