

Health, Welfare, Public Service

300  
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 4 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2448

STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6021 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <u>Ray</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural-Grape Grove Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Grape Grove Twp.</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>2 mi. W Rogal, Mo</u>		Length of stay in lb <u>25 yrs.</u>	d. STREET ADDRESS <u>samo</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>MAY</u> Last <u>MANSUR</u>			4. DATE OF DEATH <u>1/20/58</u> Month Day Year		
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>1/29/1888</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.
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>samo</u>	11. BIRTHPLACE (City and state or country) <u>Colony, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Arch W. Kavanaugh</u>			14. MOTHER'S MAIDEN NAME <u>Ella Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Roy J. Mansur, RRL, Richmond, 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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u> <u>many years</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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>---</u>		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <u>Dec. 1956</u> to <u>Jan. 20, 1958</u> and last saw her <u>her</u> alive on <u>Dec. 10, 1958</u> Death occurred at <u>8:30 P.</u> m on the <u>date</u> stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. E. Goldbery M. D.</u> (Degree or title)			22b. ADDRESS <u>Braymer, Mo.</u>		22c. DATE SIGNED <u>1/22/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>1/24/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope comotory</u>	23d. LOCATION (City, town, or county) (State) <u>Ray Co., Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Michael Personal Home, Braymer, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1-27-58</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>	

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..... *Lene G. Michael.*

Licensed Embalmer No. *43*

P. O. Address *Braymer*

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.