

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED JUL 28 1993

REGISTRATION DISTRICT NO.

REGISTRAR'S NUMBER

DELAYED 235015

124 - 17-04376.4

DO NOT WRITE ON THIS STUB

5a
7 - cy
7 - st
9b
9a
9c
10
12b
12a
13a
13b
13c & l
13e
13g
14
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16
22b
23u
23 - sc1
23 - sc2
27d
27e - f
27g - st
27g - co
27g - cy
29a
29b

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

DECEDENT

VS 300 Rev. 1/89 MO 580-0695 (1-89)

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

FOR USE BY PHYSICIAN OR INSTITUTION

NAME OF DECEDENT
 Edina, Mo.
 The Edina Sentinel

1. DECEDENT'S NAME (First, Middle, Last) Lousia Frances Elliott		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) November 15 1917
4. SOCIAL SECURITY NO. none	5a. AGE - Last Birthday (Years) 73	5b. UNDER 1 YEAR MONTHS DAYS 5	5c. UNDER 1 DAY HOURS MINUTES
6. DATE OF BIRTH (Month, Day, Year) October 10 1844		7. BIRTHPLACE (City and State or Foreign Country) Washington Co. Ohio	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.			
9a. PLACE OF DEATH (check only one; see instructions on other side) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (specify)			
9b. FACILITY NAME (If not institution, give street and number) Route # 2, Hurdland, Missouri		9c. CITY, TOWN, OR LOCATION OF DEATH Farm near Hurdland, Mo.	9d. COUNTY OF DEATH Knox
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed	11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Farm
13a. RESIDENCE - STATE Missouri	13b. COUNTY Knox	13c. CITY, TOWN, OR LOCATION Hurdland, Missouri	13d. ZIP CODE none
13e. STREET AND NUMBER None		13f. INSIDE CITY LIMITS <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13g. YEARS AT PRESENT ADDRESS <input type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input checked="" type="checkbox"/> 10-19 <input type="checkbox"/> 20 or more
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		15. RACE - American Indian, Black, White, etc. (Specify) White	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years
17. FATHER'S NAME (First, Middle, Last) Benjamin F Wyer		18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Stephens	
19a. INFORMANT'S NAME (Type/Print) Edith Elliott Hull		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route # 1, Box 148. Arenzville, Illinois 62611	
20a. BURIAL, CREMATION, OTHER (Specify) Burial	20b. DATE OF DISPOSITION (Month, Day, Year) 11-17-1917	20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Mt. Tabor Cemetary	20d. LOCATION - City or Town, State Hurdland, Missouri
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		22a. NAME AND ADDRESS OF FACILITY	22b. FUNERAL ESTABLISHMENT LICENSE NUMBER
23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Dropsy; The abnormal accumulation of serous fluid in the cellular tissue. Hydrops, Edema. old age SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST b. c. d.			Approximate Interval Between Onset and Death 6 Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY M	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.
27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		27e. DESCRIBE HOW INJURY OCCURRED	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)		27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
28a. (Specify) next of kin <input type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> MEDICAL EXAMINER/CORONER		28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Edith Elliott Hull	28c. DATE SIGNED (Month, Day, Year) 7-14-93
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)		29b. MO. LICENSE NUMBER	30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		32. REGISTRAR'S SIGNATURE Garland H. Land	33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) July 28, 1993

Affidavit of Edith Elliott Hull. Picture of tombstone & a copy of the obituary taken from the Edina Sentinel.

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 _____

Licensed Embalmer No. _____

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

SEE EXAMPLES BELOW.

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE <i>(disease or injury that initiated events resulting in death)</i> LAST	a.	Rupture of myocardium DUE TO (OR AS A CONSEQUENCE OF):				Mins.	
	b.	Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):				6 days	
	c.	Chronic ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF):				5 years	
	d.						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24. IF DECEASED WAS FEMALE 10-49 WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	
Diabetes, Chronic obstructive pulmonary disease, smoking						25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED	
		27a. DATE OF INJURY M	27b. TIME OF INJURY M	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE <i>(disease or injury that initiated events resulting in death)</i> LAST	a.	Cerebral laceration DUE TO (OR AS A CONSEQUENCE OF):				10 mins.	
	b.	Open skull fracture DUE TO (OR AS A CONSEQUENCE OF):				10 mins.	
	c.	Automobile accident DUE TO (OR AS A CONSEQUENCE OF):				10 mins.	
	d.						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24. IF DECEASED WAS FEMALE 10-49 WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	
						25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED	
		27a. DATE OF INJURY 11/15/85	27b. TIME OF INJURY 1 p. M	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED 2-car collision-driver	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
Street				Route 4, Jefferson City, Missouri			