S. No. 300
V. 10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12478

FILED APR 21 1952

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5377 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY: DEKALB Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairport
c. LENGTH OF STAY (In this place): 5
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY: DEKALB
c. CITY (If outside corporate limits, write RURAL and give township): 1321
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): IDA
b. (Middle): MAY
c. (Last): Gilbert

4. DATE OF DEATH (Month): 4 (Day): 4 (Year): 1952

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: July 18 1873
9. AGE (In years last birthday): 79 — If under 1 year: Months / Days — If under 1 hr.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DEKALB
12. CITIZEN OF WHAT COUNTRY?: U.S.
13a. FATHER'S NAME: Jim Hockenberry
13b. MOTHER'S MAIDEN NAME: Rebecca Walkins
14. NAME OF HUSBAND OR WIFE: -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Mrs Warren Byrd
ADDRESS: Fairport Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — 10 yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4201
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May, 1944, *to* April 4, 1952, *that I last saw the deceased alive on* April 4, 1952, *and that death occurred at* 11:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Harold Fowler (Degree or title): M.D.
23b. ADDRESS: Maryville, Mo
23c. DATE SIGNED: 4/5/52

24a. BURIAL, CREMATION, REMOVAL (Specify): A
24b. DATE: April 7
24c. NAME OF CEMETERY OR CREMATORY: Fairport
24d. LOCATION (City, town, or county): Fairport (State): Mo

DATE REC'D BY LOCAL REG.: 4-9-52
REGISTRAR'S SIGNATURE: Rosie Davidson
25. FUNERAL DIRECTOR'S SIGNATURE: John Brom
ADDRESS: Maryville Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Student Embalmer

Signed John Brum

Licensed Embalmer No. 3933

P. O. Address Maysville Mo

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 this body is not embalmed, fact should be so stated above.