S. No. 300
v. 10.48

APR 29 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15380

BIRTH NO. _____ REG. DIST. NO. 353 PRIMARY REG. DIST. NO. 6196 Registrar's No. 91070

1. PLACE OF DEATH
a. COUNTY Texas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Sherrill
c. LENGTH OF STAY (in this place) 4 mos
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 Texas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Shoal Boone
d. STREET ADDRESS (If rural, give location) 3 Mi. S. of Licking Mo

3. NAME OF DECEASED (Type or Print) a. (First) Cora b. (Middle) Bell c. (Last) Hadley
4. DATE OF DEATH (Month) 4 (Day) 14 (Year) 1952
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Mar 16, 1872
9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (State or foreign country) Cooksville Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Malone
13b. MOTHER'S MAIDEN NAME Not Known
14. NAME OF HUSBAND OR WIFE ✓
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT'S SIGNATURE OR NAME Leslie Hadley ADDRESS Slabtown 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) Acute Cardiac Dilatation & Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic Valvular Heart Dis Grade IV
DUE TO (c) asthma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile - Arteriosclerosis Severe

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4214
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* Mar 15, 1950, *to* Apr. 14, 1952, *that I last saw the deceased alive on* Apr. 14, 1952, *and that death occurred at* 2 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) T. J. Burns, M.D.
23b. ADDRESS Houston, Mo
23c. DATE SIGNED 4/17/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE April 16, 1952
24c. NAME OF CEMETERY OR CREMATORY Craddock Cem.
24d. LOCATION (City, town, or county) Licking (State) Mo

DATE REC'D BY LOCAL REG. April 23, 1952
REGISTRAR'S SIGNATURE Elnora Hesse 324
25. FUNERAL DIRECTOR'S SIGNATURE Smith & Ferguson ADDRESS Licking Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 Me

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Eubert E Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking 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.