

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31023

State File No.

59

FILED SEP 29 1952

BIRTH NO. _____ REG. DIST. NO. 61 PRIMARY REG. DIST. NO. 4107 Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY <u>Cedar</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Of Dorado Springs</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Of Dorado Springs 0201</u> | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) <u>112 High Tower</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bullcock Nursing Home</u> | | | |

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|---|------------|-----------------------|---------------------------|--|----------------------|
| 3. NAME OF DECEASED (Type or Print) <u>Nellie</u> | a. (First) | b. (Middle) <u>J.</u> | c. (Last) <u>Stoyback</u> | 4. DATE OF DEATH <u>Sept. 22, 1952</u> | (Month) (Day) (Year) |
|---|------------|-----------------------|---------------------------|--|----------------------|

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|----------------------|-------------------------------|---|-----------------------------------|---|------------------------------|----------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>2-19-1875</u> | 9. AGE (In years last birthday) <u>77</u> | IF UNDER 1 YEAR: Months Days | IF UNDER 6 HRS. Hours Min. |
|----------------------|-------------------------------|---|-----------------------------------|---|------------------------------|----------------------------|

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| 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>none</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Albion</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Abraham Wampler</u> | 13b. MOTHER'S MAIDEN NAME <u>Marion King</u> | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> |
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|---|-------------------------------------|---|-------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Blanch Stoyback - Neighbor</u> | ADDRESS <u>no</u> |
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| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> | | 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) _____ DUE TO (c) _____ | | |
| | II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|--|--|---|
| 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) |
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| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9 P m., from the causes and on the date stated above.

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|---|----------------------------|--|---------------------------------|
| 23a. SIGNATURE <u>Mrs. Emma Coroner</u> | (Degree or title) <u>5</u> | 23b. ADDRESS <u>Of Dorado Springs Mo</u> | 23c. DATE SIGNED <u>9-24-52</u> |
|---|----------------------------|--|---------------------------------|

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|--|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>9-24-52</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Schell City</u> | 24d. LOCATION (City, town, or county) (State) <u>Schell City Mo</u> |
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|--|---|---|-------------------------------------|
| DATE REC'D BY LOCAL REG. <u>SEPT. 23, 1952</u> | REGISTRAR'S SIGNATURE <u>Rev. [Signature]</u> | FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | ADDRESS <u>Cassidy Funeral Home</u> |
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418-0

(Licensed Embalmer's Statement on Reverse Side) Edwards Springs, Mo.

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

20
4

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
Student Embalmer

Signed May W. Dickering

Licensed Embalmer No. 4696

P. O. Address 2 Dorado Drive

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.