

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42653

State File No. _____

No. 300
10-48

FILED DEC 16 1952

REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 5300
Registry No. 1798

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-TWINS GROVE TWP. 1 VR		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-TWINS GROVE TWP. 0490	
d. FULL NAME OF HOSPITAL OR INSTITUTION RD #1, CARL JUNCTION, MO		d. STREET ADDRESS (If rural, give location) RD #1, CARL JUNCT. ON, MO	

3. NAME OF DECEASED (Type or Print) ANNIE	a. (First)	b. (Middle)	c. (Last) MARISON	4. DATE OF DEATH (Month) (Day) (Year) DEC 12 1952
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APR. 10, 1869	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 8 Days 2	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CARL DAHLSTROM	13b. MOTHER'S MAIDEN NAME ANNIE LARSON	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. GLEN BRYAN	ADDRESS CARL JUNCTION
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	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.			

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)
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?

22. I hereby certify that I attended the deceased from **Nov. 28, 1952**, to **Dec. 12, 1952** that I last saw the deceased alive on **Dec. 12, 1952** and that death occurred at **10:10 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Mrs. Madeline Swartz	(Degree or title)	23b. ADDRESS WEBB CITY MO.	23c. DATE SIGNED 12/13/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12/15/52	24c. NAME OF CEMETERY OR CREMATORY FOREST PARK CEM.	24d. LOCATION (City, town, or county) (State) TOPLIN MO
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DATE REC'D BY LOCAL REG. 12/13 1952	REGISTRAR'S SIGNATURE Mrs. Madeline Swartz	4741.9	25. FUNERAL DIRECTOR'S SIGNATURE Glen	ADDRESS Toplin, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

490
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RECEIVED 12-15-52

Jasper County Health Office

County File Number 52/12/989

Date Filed 12-15-52

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 _____

Licensed Embalmer No. 4593

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