

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6988

State File No. ....

31

BIRTH NO. ....		REG. DIST. NO. <u>251</u>		PRIMARY REG. DIST. NO. <u>3048</u>		Registrar's No. ....	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment)			
a. COUNTY <u>Nodaway</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marysville Mo</u>		c. LENGTH OF STAY (in this place) <u>2 weeks</u>		a. STATE <u>neb.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brownville neb.</u>		d. STREET ADDRESS (If rural, give location)		b. COUNTY <u>?</u> <u>2-10-1953</u>	
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>Margaret</u>		b. (Middle) <u>Jane</u>		c. (Last) <u>Sly</u>		6. COLOR OR RACE <u>white</u>	
(Type or Print)		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<u>Margaret Jane Sly</u>		<u>Widowed</u>		<u>Jan 12 - 1864</u>		<u>89</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>				<u>Ohio</u>			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
<u>Jacob Harley Trakes</u>			<u>Margaret Black</u>			<u>Geo Sly (deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME			
<u>no</u>		<u>no</u>		<u>Mrs. Eva James - Brownville, Neb.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular accident</u>				<u>24 hours</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) <u>Generalized Arteriosclerosis</u>					
		<u>Diabetes mellitus and</u>					
		<u>Fractured neck of rt femur.</u>					
		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"/>	
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) (min.)		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 <u>Jan 25, 1953</u> , to <u>Feb 8, 1953</u> , that I last saw the deceased alive on <u>Feb 8, 1953</u> , and that death occurred at <u>6:40 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)			23b. ADDRESS			23c. DATE SIGNED	
<u>Wallace Carpenter Mo</u>			<u>Rock Port Mo</u>			<u>2-10-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Feb 10 - 53</u>		<u>Elmwood Cemetery</u>		<u>Rock Port Mo</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>2-14-53</u>		<u>Bess Holt 229</u>		<u>Bethune Funeral Home - Rock Port Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

07420

**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 \_\_\_\_\_

*C. E. Bertram*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

*C. E. Bertram*

Signed *C. E. Bertram* \_\_\_\_\_

Signed.....  
Student Embalmer

Licensed Embalmer No. *1764*

P. O. Address *Rock - Port 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.