

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10695

State File No. _____

FILED MAR 31 1953

BIRTH NO. _____ REG. DIST. NO. 231²³² PRIMARY REG. DIST. NO. 5812 Registrar's No. 5-

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Prairie</u> OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Prairie</u> OR TOWN <u>0700</u>	
c. LENGTH OF STAY (in this place) <u>7 years</u>		d. STREET ADDRESS (If rural, give location) <u>4 mi. N. W. of Belleflower</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 miles N. W. Belleflower</u>		d. STREET ADDRESS (If rural, give location) <u>4 mi. N. W. of Belleflower</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>FANNIE</u>	b. (Middle) <u>LEE</u>	c. (Last) <u>HOFFMAN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 28 1953</u>
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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>Aug. 22, 1867</u>	9. AGE (In years last birthday) <u>85</u>	# UNDER 1 YEAR <u>7</u> Months	# UNDER 1 YEAR <u>6</u> Days	# UNDER 1 HRS. <u>0</u> Hours	# UNDER 1 HRS. <u>0</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pike County Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Thomas Finley</u>	13b. MOTHER'S MAIDEN NAME <u>Susana Leeper</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> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. W. W. Worsham</u> ADDRESS <u>Belleflower Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 am.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>		
	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 3/24, 1953, to 3/28, 1953, that I last saw the deceased alive on 3/28, 1953, and that death occurred at 1:30 PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Willis H. Walls M.D.</u>	23b. ADDRESS <u>Wellsville Mo.</u>	23c. DATE SIGNED <u>3/28/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/30/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville City Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Wellsville, Montg. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Mar. 28-53</u>	REGISTRAR'S SIGNATURE <u>Mrs. Zoe Chapman</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Wells, Wellsville Mo.</u> ADDRESS
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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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 W. B. Wells

Licensed Embalmer No. _____

P. O. Address Wellsville, W. Va.

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.