

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17539

State File No. _____

No. 300
10.48

FILED MAY 28 1953

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4172 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <u>Dekalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dekalb</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stewartsville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stewartsville</u> <u>0320</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Madge</u>	b. (Middle) <u>Ellen</u>	c. (Last) <u>Head</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>14</u> <u>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>Single</u>	8. DATE OF BIRTH <u>Sept. 17, 1882</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Creston, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Alfred W. Head</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Lambert</u>	14. NAME OF HUSBAND OR WIFE <u>**</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Truman Bowen</u>	ADDRESS <u>St Joseph, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>5 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Insufficiency</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma Uterus + colon</u> 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 <u>174x</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 March, 1953, to May 14, 1953, that I last saw the deceased alive on May 14, 1953, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. J. Dwyer, M.D.</u>	(Degree or title)	23b. ADDRESS <u>Stewartsville, Mo.</u>	23c. DATE SIGNED <u>5-19-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/27/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Stewartsville</u>	24d. LOCATION (City, town, or county) (State) <u>Stewartsville Mo.</u>
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DATE REC'D BY LOCAL REG. <u>5-20-53</u>	REGISTRAR'S SIGNATURE <u>Lawrence Davidson</u>	42	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Sumner</u>	ADDRESS <u>Stewartsville Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

OCT 8 1953

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 E Summerfield*

Licensed Embalmer No. *3007*

P. O. Address *Stuartsville 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.