

FILED JUN 8 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 188228

BIRTH NO.		REG. DIST. NO. 251	PRIMARY REG. DIST. NO. 4370	Registrar's No. 105
1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE IOWA b. COUNTY Page		
b. CITY (If outside corporate limits, write RURAL and give township) Clearmont		c. LENGTH OF STAY (In this place) 3 Months	c. CITY (If outside corporate limits, write RURAL and give township) Northboro 8140	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 8		
3. NAME OF DECEASED (Type or Print) a. (First) Nancy		b. (Middle) Caroline	c. (Last) Haynie	4. DATE OF DEATH (Month) (Day) (Year) May-30-1953
5. SEX Female	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July-16-1859	9. AGE (In years last birthday) 94 if UNDER 1 YEAR: Months Days if UNDER 1 Mth. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done in present or in former life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gen House work		11. BIRTHPLACE (State or foreign country) Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME W W Crewdson		
13b. MOTHER'S MAIDEN NAME Sarah Caudle		14. NAME OF HUSBAND OR WIFE J W Haynie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter Haynie Northboro, Ia
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro vascular occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebro vascular sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility		INTERVAL BETWEEN ONSET AND DEATH 48 hours no glass
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332X		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 Feb 26, 1953 , to May 30, 1953 , that I last saw the deceased alive on May 30, 1953 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE Harold Ford		23b. ADDRESS Emmo Mo.		23c. DATE SIGNED June 1-53
24a. BURIAL CREMATION REMOVAL (Specify) Removal		24b. DATE June-2-1953		24c. NAME OF CEMETERY OR CREMATORY Glen Wood
24d. LOCATION (City, town, or county) (State) Glenwood, Iowa		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Westboro, Mo		
DATE REC'D BY LOCAL REG. 6-6-53		REGISTRAR'S SIGNATURE Bess Bolt		

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

740
1

10001 2 2 11007

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, ~~###~~ ###

~~#####~~

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ashley P. T. [Signature]

Licensed Embalmer No. 4757

P. O. Address Westboro, Missouri

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.