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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 10 1953

State File No. 25578

BIRTH NO. REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3040 Registrar's No. 1169

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe	c. LENGTH OF STAY (In this place) 1 year	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe	
d. FULL NAME OF HOSPITAL OR INSTITUTION 221 Herriford Street		d. STREET ADDRESS (If rural, give location) 221 Herriford Street	

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3. NAME OF DECEASED (Type or Print) a. (First) Daisy b. (Middle) Virginia c. (Last) Romesburg			4. DATE OF DEATH (Month) (Day) (Year) August 2, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 28, 1885		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hardin, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Arthur A. Price		13b. MOTHER'S MAIDEN NAME Dolly V. Philpott		14. NAME OF HUSBAND OR WIFE Clarence R. Romesburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS C. R. Romesburg; Chillicothe, Missouri		

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis unknown			
		DUE TO (c) Hypertensive Cardiovascular disease			
		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?		

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22. I hereby certify that I attended the deceased from July 29, 1953 to Aug 2, 1953, that I last saw the deceased alive on Aug 2, 1953, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William L. Fair		23b. ADDRESS Chillicothe, Mo		23c. DATE SIGNED 8/3/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-4-53	24c. NAME OF CEMETERY OR CREMATORY Hutchinson	24d. LOCATION (City, town, or county) (State) Livingston County, Missouri		
DATE REC'D BY LOCAL REG. 8/3/53	REGISTRAR'S SIGNATURE Frances B. Need	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Norman Funeral Home; Chillicothe, Mo.			

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 *Elton F. Norman*

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.