No. 300
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FILED JUL 20 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27477

BIRTH NO. _____ REG. DIST. NO. 354 PRIMARY REG. DIST. NO. 6198 Registrar's No. 61

1. PLACE OF DEATH
a. COUNTY: TEXAS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL CASS
c. LENGTH OF STAY (in this place): LIFE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY: TEXAS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL CASS 1000
d. STREET ADDRESS (If rural, give location): 8 MI S. HOUSTON

3. NAME OF DECEASED (Type or Print)
a. (First): JULIA
b. (Middle): ANN
c. (Last): ICE

4. DATE OF DEATH (Month) (Day) (Year): 7-3-53

5. SEX: FEMALE
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 3-10-1908
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ST. LOUIS MO
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: FRANKLIN STANKEY
13b. MOTHER'S MAIDEN NAME: MATTIE SMITH
14. NAME OF HUSBAND OR WIFE: CALVIN ICE

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.: 498-38-8665
17. INFORMANT'S SIGNATURE OR NAME: CALVIN ICE
ADDRESS: HOUSTON, MO

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min

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.: Auricular Fibrillation — 2 weeks

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4201
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* on June 30, 1953, *to* _____, 19__, *that I last saw the deceased alive on* June 30, 1953, *and that death occurred at* 11:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Garrett Hoggy Jr. MD
23b. ADDRESS: Cabool Mo
23c. DATE SIGNED: July 7/53

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 7-6-53
24c. NAME OF CEMETERY OR CREMATORY: OZARK
24d. LOCATION (City, town, or county) (State): TEXAS CO MO

DATE REC'D BY LOCAL REG.: 7-8-53
REGISTRAR'S SIGNATURE: Gaynell Cunningham 325-0
25. FUNERAL DIRECTOR'S SIGNATURE: ELLIOTT FUNERAL HOME
ADDRESS: HOUSTON MO

(Licensed Embalmer's Statement on Reverse Side)

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

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 Frank Wood

Licensed Embalmer No. 4026

P. O. Address Houston 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.