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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31359**

FILED SEP 28 1953

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3012** Registrar's No. **111**

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE mo. b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give township) Boonville		c. CITY (If outside corporate limits, write RURAL and give township) New Franklin mo.	
c. LENGTH OF STAY (in this place) 3 wks.		d. STREET ADDRESS (If rural, give location) 0450	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print) Edith MAE	a. (First)	b. (Middle)	c. (Last) YooS	4. DATE OF DEATH (Month) (Day) (Year) Sept. 18 - 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar 9 1901	9. AGE (In years) (Months) (Days) (Hours) (Mins.) 52
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New Franklin Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wm. Lee Cox	13b. MOTHER'S MAIDEN NAME Sarah Celeste Pauline E. YooS	14. NAME OF HUSBAND OR WIFE
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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 E. C. Bethke	ADDRESS New Franklin Mo
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) INFARCTION, PULMONARY; EMBOLIC.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CHOLELITHIASIS; CHOLECYSTITIS, ACUTE; & CHOLECYSTECTOMY. DUE TO (c) CHRONIC RHEUMATIC HEART DISEASE.		

19a. DATE OF OPERATION 9-14-53	19b. MAJOR FINDINGS OF OPERATION INFLAMMED GALLBLADDER CONTAINING STONES.	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) 584x
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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 **AUG. 30**, 19**53**, to **SEPT. 18, 1953**, that I last saw the deceased alive on **SEPT. 18, 1953**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William M.D.	23b. ADDRESS 329 MAIN, BOONVILLE, MISSOURI	23c. DATE SIGNED 9-20-53
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE Sept. 20 - 53	24c. NAME OF CEMETERY OR CREMATORY Mc. Pleasant	24d. LOCATION (City, town, or county) (State) New Franklin mo
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DATE REC'D BY LOCAL REG. 9/20/53	REGISTRAR'S SIGNATURE D. Hooper	25. FUNERAL DIRECTOR'S SIGNATURE H. L. Hall	ADDRESS New Franklin mo
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(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

W. L. Hall

Licensed Embalmer No.

3515

P. O. Address

New Franklin

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.