

TYPE/PRINT IN PERMANENT BLACK INK. FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

FILED DEC 1 1993

MISSOURI DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

5a 7 - cy 7 - sl 9b 9a 9c 10 12b 12a 13a 13b 13c & 1 13e 13g 14 15 16 22b 23u 23 - sc1 23 - sc2 27d 27e - f 27g - sl 27g - co 27g - cy 29a 29b

REGISTRATION DISTRICT NO. 209

REGISTRAR'S NUMBER 109

DELAYED

124 - 53 - 045721

INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

1. DECEDENT'S NAME (First, Middle, Last) Fanny Cecil Mourning 2. SEX F. 3. DATE OF DEATH (Month, Day, Year) Sept 24, 1953

4. SOCIAL SECURITY NO. 5a. AGE - Last Birthday (Years) 67 5b. UNDER 1 YEAR MONTHS DAYS 5c. UNDER 1 DAY HOURS MINUTES 6. DATE OF BIRTH (Month, Day, Year) June 8, 1886 7. BIRTHPLACE (City and State or Foreign Country) Mound City, Kansas

DECEASED

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? 9a. PLACE OF DEATH (check only one; see instructions on other side) HOSPITAL: Inpatient ER/Outpatient DOA OTHER: Nursing Home Residence Other (specify) Residence

VS 300 Rev. 1/89 MO 580-0695 (1-89)

9b. FACILITY NAME (if not institution, give street and number) Rt. 2 9c. CITY, TOWN, OR LOCATION OF DEATH Crane, 9d. COUNTY OF DEATH Stone

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed 11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Housewife 12b. KIND OF BUSINESS OR INDUSTRY Own Home

13a. RESIDENCE - STATE Missouri 13b. COUNTY Stone 13c. CITY, TOWN, OR LOCATION Crane 13d. ZIP CODE 65633

13e. STREET AND NUMBER Rt. 2 13f. INSIDE CITY LIMITS 13g. YEARS AT PRESENT ADDRESS Yes No Under 5 5-9 10-19 20 or more

14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No Yes Specify: 15. RACE - American Indian, Black, White, etc. (Specify) White 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)

17. FATHER'S NAME (First, Middle, Last) Unknown Lane 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown

PARENTS

19a. INFORMANT'S NAME (Type/Print) Harlan Gatton 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 322 Crane, MO 65633

INFORMANT

20a. BURIAL, CREMATION, OTHER (Specify) Burial 20b. DATE OF DISPOSITION (Month, Day, Year) 9-26-53 20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Masonic Cemetery 20d. LOCATION - City or Town, State Crane, MO

DISPOSITION

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH 22a. NAME AND ADDRESS OF FACILITY Manlove Funeral Home 22b. FUNERAL ESTABLISHMENT LICENSE NUMBER 2369

SEE INSTRUCTIONS ON OTHER SIDE

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Natural Causes

CAUSE OF DEATH

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? 25a. WAS AN AUTOPSY PERFORMED? 25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

26. MANNER OF DEATH 27a. DATE OF INJURY (Month, Day, Year) 27b. TIME OF INJURY 27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) 27d. INJURY AT WORK? 27e. DESCRIBE HOW INJURY OCCURRED

CERTIFIER

27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify) 27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28a. (Specify) CERTIFYING PHYSICIAN MEDICAL EXAMINER/CORONER 28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Fred L. Wommack, M.D. 28c. DATE SIGNED (Month, Day, Year) 11-16-93 28d. TIME OF DEATH unknown

29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) Fred L. Wommack, M.D. Crane, MO 65633 29b. MO. LICENSE NUMBER 21882 30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes No

31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) n/a 32. REGISTRAR'S SIGNATURE Brenda Smithson 33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) 11-17-93

CERTIFIER

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. *with down*

Student _____ Signature of Student Embalmer _____ Signed _____

Licensed Embalmer No. _____

P.O. Address _____

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

SEE EXAMPLES BELOW.

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	<u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):			Mins.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b.	<u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):			6 days
	c.	<u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):			5 years
	d.	_____ DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>				25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY M <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED
	27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	<u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF):			10 mins.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b.	<u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF):			10 mins.
	c.	<u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF):			10 mins.
	d.	_____ DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY 1 p. M <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED
	27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
	Street	Route 4, Jefferson City, Missouri			