

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **395**
Registrar's No. **124**

BIRTH NO. **FILED FEB 8 1954** REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **4059**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Neelyville		c. LENGTH OF STAY (In this place) 9yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Neelyville	
		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) Narka b. (Middle) Fearl c. (Last) Standeford			4. DATE OF DEATH (Month) (Day) (Year) Jan 27 1954		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 23 1889	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Reno Ark.	12. CITIZEN OF WHAT COUNTRY? usa
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13a. FATHER'S NAME William Zimmerman	13b. MOTHER'S MAIDEN NAME Nellie Hayes	14. NAME OF HUSBAND OR WIFE Albert Standeford
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Nellie Zimmerman ADDRESS Neelyville 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbidity 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 **Jan. 26, 1954** to **Jan. 27, 1954**, that I last saw the deceased alive on **Jan. 27, 1954**, and that death occurred at **10:01 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. L. Smith, D.O.	23b. ADDRESS Box 328 Neelyville, Mo.	23c. DATE SIGNED 1-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-28-54	24c. NAME OF CEMETERY OR CREMATORY St. Carmel, Ill.	24d. LOCATION (City, town, or county) (State) St. Carmel, Ill.
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DATE REC'D BY LOCAL REG 1/29/54	REGISTRAR'S SIGNATURE J. W. Mueller	25. FUNERAL DIRECTOR'S SIGNATURE Sisk Funeral Home ADDRESS Naylor, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0122

RECEIVED
FEB 2 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

AUG 28 1959

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

Bryan McCord

Licensed Embalmer No. *4079*

P. O. Address *Naylor, 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.