

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12840**

BIRTH NO. _____ REG. DIST. NO. **258** PRIMARY REG. DIST. NO. **4390** Registrar's No. **57**

1. PLACE OF DEATH a. COUNTY OSAGE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY OSAGE	
b. CITY (If outside corporate limits, write RURAL and give town) META	c. LENGTH OF STAY (in this place) 4 mos.	c. CITY (If outside corporate limits, write RURAL and give township) META	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED a. (First) MARY b. (Middle) LAVADA c. (Last) HART			4. DATE OF DEATH (Month) (Day) (Year) April 22 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 19, 1872
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR (Months) (Days) 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) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. NAME OF HUSBAND OR WIFE WILLIAM T. HART	
13a. FATHER'S NAME JAMES Reed		13b. MOTHER'S MAIDEN NAME MARY Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Florence Rowan		ADDRESS Meta Missouri	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Ventricular Failure INTERVAL BETWEEN ONSET AND DEATH 3 days *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) Nephrosis 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: 446X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/1/1954 , to 4/22/1954 , that I last saw the deceased alive on 4/22/1954 , and that death occurred at 2:20 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE J.W. Foster D.O. (Degree or title)		23b. ADDRESS Meta Mo	
23c. DATE SIGNED 4/22/54			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4/24/54	
24c. NAME OF CEMETERY OR CREMATORY CARL JUNCTION Cemetery		24d. LOCATION (City, town, or county) (State) CARL JUNCTION Missouri	
DATE REC'D BY LOCAL REG. 4-22-54		REGISTRAR'S SIGNATURE 2367 Rose Rowan	
25. FUNERAL DIRECTOR'S SIGNATURE Walter Hedges		ADDRESS Meta, Mo.	

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

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APR 27 1954

APR 28 1954

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

Walter P. Hedges

Licensed Embalmer No.

14265

P. O. Address

Berlin, 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.