

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22268**

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **236**

2

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

1. PLACE OF DEATH a. COUNTY Calloway		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Mo b. COUNTY Calloway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		c. LENGTH OF STAY (in this place) 8 years 10 mo	c. CITY OR TOWN Sedalia
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian State Hosp. #1		e. STREET ADDRESS (If rural, give location) 0807	

3. NAME OF DECEASED (Type or Print)	a. (First) SELMA	b. (Middle)	c. (Last) ELIZABETH CHRISTIAN	4. DATE OF DEATH (Month) (Day) (Year) 7-31-54
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5. SEX F	6. COLOR OR RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Unknown	9. AGE (in years last birthday) 87 3/4	IF UNDER 1 YEAR Months 7	IF UNDER 1 HR. Hours 2	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DK	10b. KIND OF BUSINESS OR INDUSTRY DK	11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE Unknown
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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) DK	16. SOCIAL SECURITY NO. DK	17. INFORMANT'S SIGNATURE OR NAME State Hosp #1	ADDRESS Fulton Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chron. myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis 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)	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 **9-15-1945**, to **7-31-1954** that I last saw the deceased alive on **7-30-1954**, and that death occurred at **5-2** p.m., from the causes and on the date stated above.

23a. SIGNATURE D. Hunter by D. J. French	23b. ADDRESS State Hospital Fulton	23c. DATE SIGNED 7-31-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug 5-1954	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) Kirksville Mo
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DATE REC'D BY LOCAL REG. Aug 5-1954	REGISTRAR'S SIGNATURE Margaret Lawrence	426	25. FUNERAL DIRECTOR'S SIGNATURE Wallace Funeral Home	ADDRESS Fulton Mo
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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 No. Cavity work done, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed William C. Treks

Licensed Embalmer No. 4876

P. O. Address Hutton

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.