

FILED SEP 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31331

BIRTH NO. _____ REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 3048 Registrar's No. 219

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Nodaway	
b. CITY (If outside corporate limits, write RURAL and give township) Maryville		c. CITY (If outside corporate limits, write RURAL and give township) Rural Independence Twp.	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 0740	
d. FULL NAME OF (If not in hospital or institution, give street address or location) St. Francis Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Eva		b. (Middle)		c. (Last) Lester		4. DATE OF DEATH (Month) (Day) (Year) Sept. 7, 1954	
--	--	-------------	--	-------------------------	--	---	--

5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 27, 1887		9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. 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) Athelston, Iowa				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
---	--	-----------------------------------	--	---	--	--	--	---	--

13a. FATHER'S NAME William Morris		13b. MOTHER'S MAIDEN NAME Martha Freemyer		14. NAME OF HUSBAND OR WIFE John Lester			
---	--	---	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME John Lester, Hopkins, Mo.				ADDRESS	
---	--	--	--	---	--	--	--	---------	--

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolus						INTERVAL BETWEEN ONSET AND DEATH 27 hours	
		ANTECEDENT CAUSES Morbid 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 332 X						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 _____, 1950, to **Sept 7, 1954**, that I last saw the deceased alive on **Sept 7, 1954**, and that death occurred at **5:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Frank B. Matheson MD		(Degree or title)		23b. ADDRESS Grant City Mo		23c. DATE SIGNED 9-8-54	
---	--	-------------------	--	--------------------------------------	--	-----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 9-10-54		24c. NAME OF CEMETERY OR CREMATORY New Hope		24d. LOCATION (City, town, or county) (State) Rural-Hopkins, Mo.	
--	--	-----------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. 9-18-54		REGISTRAR'S SIGNATURE Gloss Holt		25. FUNERAL DIRECTOR'S SIGNATURE Stanley Swanson		ADDRESS Hopkins, Mo.	
--	--	--	--	--	--	--------------------------------	--

(Licensed Embalmers' 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 _____

myself

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Stanley Swanson

Licensed Embalmer No. 3063

P. O. Address Hopkins, 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.