

FILED NOV 10 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34572

BIRTH NO. _____ REG. DIST. NO. 195 PRIMARY REG. DIST. NO. 4309 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY McDonald		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY McDonald	
b. CITY (If outside corporate limits, write RURAL and give town) Southwest City		c. LENGTH OF STAY (in this place) 4 1/2 yrs	c. CITY OR TOWN Southwest City
d. FULL NAME OF HOSPITAL OR INSTITUTION None		STREET ADDRESS (If rural, give location) 0600	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) — c. (Last) Hatfield			4. DATE OF DEATH (Month) (Day) (Year) 10-8-54		
5. SEX Female	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH Feb 14-1871		9. AGE (In years last birthday) 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Freeport Ill.		12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME Mathias Peters		13b. MOTHER'S MAIDEN NAME Cathrine Critz		14. NAME OF HUSBAND OR WIFE Henry Hatfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Maude Sayre ADDRESS Southwest City, Mo.	

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) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Cardiac Decompensation		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. cardenility decompensation		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4221		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 **Sept. 19 53**, to **10-8**, 19 **54**, that I last saw the deceased alive on **10-8**, 19 **54**, and that death occurred at **9:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R.E. Warrack, M.D.		23b. ADDRESS Southwest City, Mo.	23c. DATE SIGNED 11-1-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-11-54	24c. NAME OF CEMETERY OR CREMATORY Southwest City Cem.	24d. LOCATION (City, town, or county) (State) Southwest City, Mo.
DATE REC'D BY LOCAL REG. 11-1-54	REGISTRAR'S SIGNATURE Maude Humphrey	25. FUNERAL DIRECTOR'S SIGNATURE T.M. Humphrey	ADDRESS Noel, Mo.

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

0600

MAR 8 1956

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
Signature of Student Embalmer

Signed *W. M. Humphrey Jr.*

Licensed Embalmer No. 470

P. O. Address *Noel, W.*

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.