

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37853**

FILED DEC 1 1954

0480

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

BIRTH NO. _____		REG. DIST. NO. <u>170</u>		PRIMARY REG. DIST. NO. <u>3033</u>		Registrar's No. <u>203</u>	
1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>CAMDEN</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lebanon</u>		c. LENGTH OF STAY (In this place) <u>2 Wks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Decaturville</u>		d. STREET ADDRESS (If rural, give location) <u>Decaturville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wallace Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Decaturville</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Eva.</u> b. (Middle) <u>Claiborne</u> c. (Last) <u>Claiborne</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22 1954</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 19 1884</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Camden Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>W. F. Claiborne</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah E. Sharp</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>H. B. Claiborne</u> ADDRESS <u>Decaturville Mo.</u>			
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) <u>Hypertensive heart disease</u> 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. _____				INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) <u>Lebanon, Mo.</u>			
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? <u>443X</u>			
22. I hereby certify that I attended the deceased from <u>11-4-1954</u> , to <u>11-22-1954</u> , that I last saw the deceased alive on <u>11-22-1954</u> , and that death occurred at <u>12-20-54</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>B. B. Hurst, M.D.</u> (Degree or title)				23b. ADDRESS <u>Lebanon, Mo.</u>		23c. DATE SIGNED <u>11-23-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/24/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Claiborne</u>		24d. LOCATION (City, town, or county) (State) <u>Camden Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>11-24-1954</u>		REGISTRAR'S SIGNATURE <u>Abella L. May</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>S. P. Palmer</u> ADDRESS <u>Lebanon Mo</u>			

Received 11-27-54
Laclede County Health Unit
File No. 192
Date Filed 11-27-54

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Allyn Hooker

Signed.....
Student Embalmer

Licensed Embalmer No. 4333

P. O. Address Lebanon 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.