

FILED JUL 25 1955

## THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH 3073

24994

State File No. ....

BIRTH NO. ....

REG. DIST. NO. 328

PRIMARY REG. DIST. NO. 3670

Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>SCOTT</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CHAFFEE</b>		c. LENGTH OF STAY (in this place) <b>50 YRS.</b>		c. CITY OR TOWN <b>CHAFFEE</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>129 GRAY AVE.</b>				STREET ADDRESS (If rural, give location) <b>129 GRAY AVE. 100/0</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>ROSETTA</b> b. (Middle) <b>MARY</b> c. (Last) <b>ESTES</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 12, 1955</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 12, 1886</b>		9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>-</b> Min. <b>-</b>	IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>DECATUR, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>(UNKNOWN) FOSTER</b>			13b. MOTHER'S MAIDEN NAME <b>(UNKNOWN) COKEY</b>		14. NAME OF HUSBAND OR WIFE <b>J. W. ESTES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>J. W. ESTES - CHAFFEE MISSOURI</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CARDIAC DECOMPENSATION</b>				<b>3 YRS.</b>				
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>MYOCARDIOSIS, ARTERIOSCLEROSIS 5 YRS</b>				<b>4 2 2 1</b>				
DUE TO (c) <b>CARDIOVASCULAR-RENAL DISEASE</b>				<b>BRONCHIAL ASTHMA 20 YRS?</b>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION <b>NONE</b>		19b. MAJOR FINDINGS OF OPERATION <b>-</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>NATURAL</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>-</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>NONE</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>-</b>				
22. I hereby certify that I attended the deceased from <b>MARCH, 1951</b> , to <b>JULY, 1955</b> , that I last saw the deceased alive on <b>7-11</b> , 1955, and that death occurred at <b>4:43 a.m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>H. J. Muebach, D.O.</b>				23b. ADDRESS <b>Chaffee, Mo.</b>		23c. DATE SIGNED <b>7-12-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>7-14-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>PARKVIEW CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>FARMINGTON, Missouri</b>			
DATE REC'D BY LOCAL REG. <b>7-15-55</b>		REGISTRAR'S SIGNATURE <b>Mrs. Paul Bisplinghoff</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bisplinghoff Funeral Home - Chaffee, Mo.</b>				

(I.ensed Embaker's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

DATE RECEIVED

JUL 2

SCOTT CO. HEALTH DEPT

NO. FILE No. 255-1

VS MAY 31 1980

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 Jack J. Burnett  
Licensed Embalmer No. 44

P. O. Address C. Raffe

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.