

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43112**

No. 300  
10.48

FILED JAN 9 1956

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

BIRTH NO. _____		REG. DIST. NO. <b>322</b>		PRIMARY REG. DIST. NO. <b>3071</b>		Registrar's No. <b>7</b>	
1. PLACE OF DEATH a. COUNTY <b>Saline</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Saline</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Slater</b>		c. LENGTH OF STAY (in this place) <b>45 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Slater</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>None</b>				d. STREET ADDRESS (If rural, give location) <b>Jefferson</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Maude</b>		b. (Middle) <b>Ann</b>		c. (Last) <b>Kearns</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 30-'55</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>July, 30-1883</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Lexington, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S</b>	
13a. FATHER'S NAME <b>Mr.-W. Harris</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Jane Tipton</b>		14. NAME OF HUSBAND OR WIFE <b>widow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give no or dates of service) <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Bill Kearns, Slater, Mo.</b>		ADDRESS			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardio Coronary occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension Progressive</b> DUE TO (c) <b>Arteriosclerosis</b>  II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <b>4201</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Monday</b>  <b>4 yrs</b>	
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>no</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>no</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>no</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> WHILE ON TRIP <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>no</b>					
22. I hereby certify that I attended the deceased from <b>June 11, 1953</b> to <b>July 16, 1955</b> , that I last saw the deceased alive on <b>July 16, 1955</b> , and that death occurred at <b>12:30 m.</b> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>W. E. Peterson M.D.</b>			23b. ADDRESS <b>306 W. Main Slater Mo.</b>		23c. DATE SIGNED <b>7/3/56</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1/4/1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Slater, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>1-3-'56</b>	REGISTRAR'S SIGNATURE <b>Mr. Earl C. Metz</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Hill Brothers</b>		ADDRESS <b>Slater, Mo.</b>		

**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 .....  
Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Statesville, NC

**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.