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

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4526 7841

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 359 PRIMARY REG. DIST. NO: 4529- Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY: VERNON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SHELDON
c. LENGTH OF STAY (In this place): 68 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: VERNON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1080
d. STREET ADDRESS (If rural, give location): C

3. NAME OF DECEASED (Type or Print)
a. (First): MAMIE
b. (Middle): R
c. (Last): HATCH

4. DATE OF DEATH (Month) (Day) (Year): Feb 17 1956

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: DEC 31 1862
9. AGE (In years last birthday): 93 — If under 1 year: Months: 1 Days: 17 — If under 1 hr.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): DANBOROUGH PA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: NATHAN R. SHEPHERD
13b. MOTHER'S MAIDEN NAME: SARAH B SHAW
14. NAME OF HUSBAND OR WIFE: MARION ARTHUR HATCH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: Miss Inez Hatch — **ADDRESS**: Sheldon, Mo

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parotid Tumor — Years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1949, 19__, *to* Feb. 17, 1956 *that I last saw the deceased alive on* Feb. 17, 1956, *and that death occurred at* 9:00 pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Herbert M. Arnold M.D.
23b. ADDRESS: Lamar, Missouri
23c. DATE SIGNED: 2-22-56

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: Feb 20 1956
24c. NAME OF CEMETERY OR CREMATORY: SHELDON
24d. LOCATION (City, town, or county): VERNON — (State): MO

DATE REC'D BY LOCAL REG.: Feb 29 1956
REGISTRAR'S SIGNATURE: Mrs Ruth Faith
25. FUNERAL DIRECTOR'S SIGNATURE: S. Bernard Burns — **ADDRESS**:

(Licensed Embalmer's Statement on Reverse Side)

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 L. Bernard Beery

Licensed Embalmer No. 4161

P. O. Address Sheldon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.