

FILED MAY 21 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15892**

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3017** Registrar's No. **67**

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY COOPER	
b. CITY OR TOWN BOONVILLE		c. CITY OR TOWN BOONVILLE	
c. LENGTH OF STAY (In this place)		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		e. STREET ADDRESS (If rural, give location) 1231 S. MAIN ST	

3. NAME OF DECEASED (Type or Print) a. (First) SARAH b. (Middle) JANE c. (Last) HUMPHRIES			4. DATE OF DEATH (Month) (Day) (Year) MAY 13 56		
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH JAN 9 1855		9. AGE (In years last birthday) 101		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME ALFRED NEWMAN		13b. MOTHER'S MAIDEN NAME SARAH GREENE		14. NAME OF HUSBAND OR WIFE ?	
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. _____		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS ANNA BRUCE 1231 S. MAIN ST	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HTEROSCLEROSIS		DUPLICATE		?	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)			
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 **May 11, 1956** to **May 13, 1956**, that I last saw the deceased alive on **May 13, 1956**, and that death occurred at **6:30 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. DeGraffenreid MD		23b. ADDRESS Boonville Mo		23c. DATE SIGNED 5/16/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAY 17 56		24c. NAME OF CEMETERY OR CREMATORY CITY CEMETERY	
24d. LOCATION (City, town, or county) (State) BOONVILLE MO					

DATE REC'D BY LOCAL REG. 5/16/56		REGISTRAR'S SIGNATURE D. Cooper		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS MAY-PARKER 814 S. PORTER	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

881

JUN 30 1958

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..... *Edward H. Krueger*

Licensed Embalmer No. *4991*

P. O. Address *Columbia, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.