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FILED AUG 15 1956

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 22077

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 237

1. PLACE OF DEATH a. COUNTY Adair	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Adair
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kirksville — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Novinger — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) K. O. H. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) R. F. D. #3 — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Sylvia Middle Elizabeth Last Terrell

4. DATE OF DEATH: Month Aug. Day 4 Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 7, 1890

9. AGE (In years last birthday): 66 — 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): Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and state or country): Putnam County, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aaron Lawson

14. MOTHER'S MAIDEN NAME: Millie Adkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): x

16. SOCIAL SECURITY NO.: 363 07 8097B

17. INFORMANT: E. E. Terrell, Novinger, Mo. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Medulary Failure	3 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. — DUE TO (b)	Cerebral Hemorrhage	7 days
DUE TO (c)	Arterio-sclerotic hypertension	5 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 25, 1956, to August 4, 1956 and last saw her/him alive on August 4, 1956. Death occurred at 10 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Howard E. Gross, D.O.

22b. ADDRESS: Kirksville, Mo.

22c. DATE SIGNED: August 7, 1956

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8/7/56

23c. NAME OF CEMETERY OR CREMATORY: Green Grove Cemetery

23d. LOCATION (City, town, or county) (State): Adair County, Mo.

24. FUNERAL DIRECTOR: Paul M. R[illegible] — ADDRESS: Kirksville, M.

25. DATE RECD. BY LOCAL REG.: 8-11-56

26. REGISTRAR'S SIGNATURE: Kate Lambert

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Signed George W. Davalo

Student.....
Signature of Student Embalmer

Licensed Embalmer No. 47

P. O. Address Kirksv

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