

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27596**

FILED SEP 6 1956

BIRTH NO. _____ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **3041** Registrar's No. _____

| | | | |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Macon | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE Mo b. COUNTY Macon | |
| b. CITY OR TOWN Macon | c. LENGTH OF STAY (In this place) | c. CITY OR TOWN Bevier | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Shamanta Hosp. | | e. STREET ADDRESS (If rural, give location) 0670 | |

| | | | | |
|-------------------------------------|--------------------------|----------------------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Bertie | b. (Middle) Levexia | c. (Last) Twyman | 4. DATE OF DEATH (Month) (Day) (Year) 8-16-56 |
|-------------------------------------|--------------------------|----------------------------|-------------------------|--|

| | | | | | | | | |
|----------------------|-------------------------------|---|-------------------------------------|---|------------------------|-----------------------|------|------|
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH 84 12-13-53 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hour | Min. |
|----------------------|-------------------------------|---|-------------------------------------|---|------------------------|-----------------------|------|------|

| | | | |
|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic | 10b. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (City and State or Foreign Country) Keata Mo | 12. CITIZEN OF WHAT COUNTRY? Mo |
|---|--|--|--|

| | | |
|---------------------------------------|---|--------------------------------------|
| 13a. FATHER'S NAME John Inason | 13b. MOTHER'S MAIDEN NAME Janis Jensen | 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) | SOCIAL SECURITY NO. - | 17. INFORMANT'S SIGNATURE OR NAME Janet Twyman | ADDRESS Bevier 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 6 days |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Devascularization | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) | | |
| 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) 4200 |
|--|--|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | 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 **8/11, 1956** to **8/16/56, 1956**, that I last saw the deceased alive on **8/14, 1956**, and that death occurred at **5:29 a.m.**, from the causes and on the date stated above.

| | | | |
|---|-----------------------------|-------------------------------|---------------------------------|
| 23a. SIGNATURE James E. Campbell | (Degree or title) MD | 23b. ADDRESS Macon Mo. | 23c. DATE SIGNED 8/29/56 |
|---|-----------------------------|-------------------------------|---------------------------------|

| | | | |
|---|--------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 8/25/56 | 24c. NAME OF CEMETERY OR CREMATORY West Oakwood | 24d. LOCATION (City, town, or county) (State) Bevier Mo |
|---|--------------------------|--|--|

| | | | |
|---|--|--|--------------------------|
| DATE REC'D BY LOCAL REG. 8/31/56 | REGISTRAR'S SIGNATURE Walter M. Veely | 25. FUNERAL DIRECTOR'S SIGNATURE W.S. Edwards | ADDRESS Bevier Mo |
|---|--|--|--------------------------|

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

D

County File
Date Filed 9.5.56

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 *H. S. Edwards*.....

Licensed Embalmer No. *1961*

P. O. Address *Berwick 2*

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.