Health, Welfare Public Service

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29697
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 298

1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kirksville, Mo. — Inside Limits: Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Laughlin Hosp. — Length of stay in Ib: 15 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Shelby
c. CITY OR TOWN: Shelbina, Mo. — Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): West Beech — Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: Alta Middle: Elizabeth Last: Mason

4. DATE OF DEATH Month Day Year: 9-27-1956

5. SEX: Female **6. COLOR OR RACE:** White **7. MARRIED** X **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10-15-1892 **9. AGE** (In years last birthday): 63 — IF UNDER 1 YEAR: Months 11, Days 12; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing (Pratical) **10b. KIND OF BUSINESS OR INDUSTRY:** Same

11. BIRTHPLACE (City and state or country): Shelby County, Mo. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13. FATHER'S NAME: Benjamin Gaines **14. MOTHER'S MAIDEN NAME:** Susan Rachel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None **16. SOCIAL SECURITY NO.:** 492-24-1920 **17. INFORMANT** Address: Mr. Francis Mason Shelbina, Mo.

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)	Medullary paralysis	30 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. — DUE TO (b)	Metastatic carcinoma of the brain	unknown
DUE TO (c)	Carcinoma of the breast.	known 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 170 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

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 Sept. 12, 1956 to Sept. 27, 1956 and last saw her/him alive on Sept. 27, 1956
Death occurred at 4:15 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Jack Ambler D.O. **22b. ADDRESS:** Kirksville, missouri **22c. DATE SIGNED:** 9/29/56

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial **23b. DATE:** 9-30-56 **23c. NAME OF CEMETERY OR CREMATORY:** I.O.O.F. **23d. LOCATION** (City, town, or county) (State): Shelbyville, Missouri

24. FUNERAL DIRECTOR ADDRESS: Barkelew & Davis Shelbina, Mo **25. DATE RECD. BY LOCAL REG.:** 9-29-56 **26. REGISTRAR'S SIGNATURE:** Kate Lambert

(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 em

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James D. Davis

Licensed Embalmer No. 44

P. O. Address Shelbina,

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