

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32967**
REG. DIST. NO. **373** PRIMARY REG. DIST. NO. **4545** Registrar's No. **34**

FILED SEP 17 1956

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

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY WEBSTER	
b. CITY OR TOWN MARSHFIELD c. LENGTH OF STAY (in this place) 30 YRS		c. CITY OR TOWN MARSHFIELD 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) 727 W. WASHINGTON	
3. NAME OF DECEASED (Type or Print) a. (First) LUCY b. (Middle) ARLENA c. (Last) MILNER		4. DATE OF DEATH (Month) (Day) (Year) SEPT 5 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC 6 1872
9. AGE (In years last birthday) 83		if UNDER 1 YEAR Months	if UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN YOUNG		13b. MOTHER'S MAIDEN NAME MARY HUNT	
13c. NAME OF HUSBAND OR WIFE JIM.		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
15. SOCIAL SECURITY NO.		16. INFORMANT'S SIGNATURE OR NAME JIM MILNER ADDRESS MARSHFIELD	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular accident		INTERVAL BETWEEN ONSET AND DEATH 5 mins.	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Cerebral arteriosclerosis		10 years.	
DUE TO (c) Generalized arteriosclerosis		20 years.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart disease		3 years.	
		cardiac arrhythmia	
		4 years.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
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 Jan 13, 1953 , to Sept 5, 1956 , that I last saw the deceased alive on Sept 5, 1956 , and that death occurred at 12:04 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. M. Macdonnell M.D.		23b. ADDRESS Marshfield, Mo.	
23c. DATE SIGNED 8 Sept 56			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9-8-1956	
24c. NAME OF CEMETERY OR CREMATORY ST LUKE		24d. LOCATION (City, town, or county) (State) WEBSTER Co MO	
DATE REC'D BY LOCAL REG. 9-10-56		25. FUNERAL DIRECTOR'S SIGNATURE J. Francis BARBER-EDWARDS ADDRESS MARSHFIELD	

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 *George Stappa*.....

Licensed Embalmer No: *316*

P. O. Address *Wm. Lane*

**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.**