

Health,  
& Welfare  
Public  
Service

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

33304

FILED OCT 16 1956

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 264

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>			Length of stay in 1b <b>37 Years</b>		d. STREET ADDRESS <b>818 Center St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>First Ella Middle Layson Last</b>				4. DATE OF DEATH Month <b>Octo</b> Day <b>9</b> Year <b>1956</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>June 23 1869</b>		9. AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Lindberg, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>John Threlkeld</b>				14. MOTHER'S MAIDEN NAME <b>Bettie Shryock</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (Yes, give war or dates of service) <input type="checkbox"/>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Harold Houf</b> Address <b>818 Center St</b> <b>Fulton, Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>7 months</b> <b>?</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>4:30</b> Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>March 5, 1956</b> to <b>Oct. 9, 1956</b> and last saw her alive on <b>Oct. 6, 1956</b> Death occurred at <b>4:30 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Tom Brewer MD</b> (Degree or title)				22b. ADDRESS <b>Fulton, Mo.</b>		22c. DATE SIGNED <b>10-12-56</b>			
23a. BURIAL, CREMATION, REPLY TO (State or country)		23b. DATE <b>Oct-11-1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Milleesburg Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Millersburg Mo</b>			
24. FUNERAL DIRECTOR <b>Hallace Funeral Home Fulton, Mo</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>Oct 12-1956</b>		26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>			

(Licensed Embalmer's Statement on Reverse Side)

APR 2 1949

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 *Hector R. Masure*.....

Licensed Embalmer No. *499*

P. O. Address *Fulton, Ga.*

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