

Health,
Welfare
Public
Service

FILED NOV 7- 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **35188**

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 383

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

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Madison									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington, Mo. - Rural		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Mill Creek, Mo. Rt. 2		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hacienda Nursing Home			Length of stay in 1b		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Julia First J. Middle Oliver Last				4. DATE OF DEATH Month Nov. Day 2 Year 1956									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 29, 1872		9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months 7 Days 3		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Hickman Ky.			12. CITIZEN OF WHAT COUNTRY? U.S. A.				
13. FATHER'S NAME Charles Jones						14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Ferrer Address Flat River, Mo.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis: arterio-sclerotic sensitivity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) sensitivity DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4221										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 Month Day Year a. m. p. m. 													
20d. INJURY OCCURRED WHILE AT 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 <u>10-18-56</u> to <u>11-2-56</u> and last saw her ^{her} _{husb} alive on <u>11-1-56</u> Death occurred at <u>10:20 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE B. B. Ferrer MD (Degree or title)						22b. ADDRESS Flat River Mo				22c. DATE SIGNED 11-1-56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov. 4, 1956		23c. NAME OF CEMETERY OR CREMATORY Hayti Cemetery			23d. LOCATION (City, town, or county) (State) Hayti, Missouri					
24. FUNERAL DIRECTOR C. H. Cozean, Farmington, Mo. ADDRESS					25. DATE RECD. BY LOCAL REG. Nov. 6, 1956			26. REGISTRAR'S SIGNATURE Ether Redloff					

(Licensed Embalmer's Statement on Reverse Side)

87-0

1937

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..... *W. A. Cozart*
Licensed Embalmer No. *40*
P. O. Address *Farmington*

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.