

Health, Welfare and Public Service
 100-56
 Diseases in Part I must be "casually related." Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 4 - 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

37462

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. 5336 Registrar's No. 56-79

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Center twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Greenfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 1/2 Mi. W. Greenfield</u>		Length of stay in 1b <u>6 months</u>		d. STREET ADDRESS <u>3 1/2 mi. West</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Una</u> Middle <u>Page</u> Last <u>Hargis</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3, 1932</u>	
9. AGE (In years last birthday) <u>24</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (City and state or country) <u>Dade County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Elgin Clabough</u>			
14. MOTHER'S MAIDEN NAME <u>Pearl Weeks</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Charles Hargis; R.F.D. So. Greenfield, Mo.</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30-45 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Aspirated vomitus</u>				DUE TO (c) <u>9040.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>21</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) <u>Fell in bathroom + struck head on floor, loss</u>				
20c. TIME OF INJURY Hour <u>11</u> Month <u>11</u> Day <u>25</u> Year <u>56</u> <u>p. m.</u>			of consciousness <u>29</u>				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>Greenfield</u>		COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>approx. 9:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>David F. Gorchix M.D. Pathologist</u>				22b. ADDRESS <u>111 Professional Bldg. Springfield, Mo</u>		22c. DATE SIGNED <u>11-26-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 28, 1956</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Greenfield Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo.</u>	
24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-26-1956</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>	

(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 embalmed
by me, ~~or by~~....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. C. Canada*.....
Licensed Embalmer No. *41*.....

P. O. Address *Greenfield*.....

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.