

FILED DEC 10 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

40413

Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARSHFIELD, MO</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MARSHFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>187RS</u> Length of stay in 1b		d. STREET ADDRESS (If outside of location) <u>720</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MADGE</u> First Middle Last <u>HARBERT</u>		4. DATE OF DEATH <u>NOV 23 1956</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 25 1870</u>
9. AGE (In years last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>	11. BIRTHPLACE (City and state or country) <u>IOWA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JOHN HARBERT</u>	
14. MOTHER'S MAIDEN NAME <u>NANCY KEER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>GEORGE F. HARBERT</u> Address <u>MARSHFIELD</u>	
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>CONGESTIVE CIRCULATORY FAILURE</u> DUE TO (b) <u>PROLONGED RECUMBENCY NECESSITATED BY FRACTURED HIP</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> 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
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 <u>MARSHFIELD</u> COUNTY <u>WEBSTER</u> STATE <u>MO</u>		21. I attended the deceased from <u>10-25-56</u> to <u>11/23/56</u> and last saw her <u>him</u> alive on <u>11/22/56</u> Death occurred at <u>5:00</u> Am on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Dr.</u>		22b. ADDRESS <u>Marshallfield, Mo.</u>	
22c. DATE SIGNED <u>11/24/56</u>		23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>11-25-1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD</u>	
23d. LOCATION (City, town, or county) <u>MARSHFIELD</u> (State) <u>MO</u>		24. FUNERAL DIRECTOR <u>BARBER-EDWARDS</u> ADDRESS <u>MARSHFIELD</u>	
25. DATE RECD. BY LOCAL REG. <u>11-29-56</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

DISEASES IN PART I MUST BE CASUALLY RELATED. CORRECTOR CANNOT CERTIFY TO A DEATH DUE TO NATURAL CAUSES.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

Student.....  
Signature of Student Embalmer

Signed.....  
*T. W. Barber*

Licensed Embalmer No. 3

P. O. Address *W. H. Kro*

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.