

Health, Welfare
Public Service

300
9-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42043

FILED DEC 24 1956

STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY Lawrence				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence			
b. CITY (If outside corporate limits, give TOWNSHIP only) Aurora			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Aurora		055/0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION 1019 S. Madison			Length of stay in lb Lyear	d. STREET ADDRESS (If outside, give location) 1019 S. Madison			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle EMMA Last WATSON				4. DATE OF DEATH Month Dec. Day 21 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 2/14/1876	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	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 Home	11. BIRTHPLACE (City and state or country) Effingham County, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Crosier				14. MOTHER'S MAIDEN NAME Harriett Tizer			
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 Ida Jennings, Aurora, Mo				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure Coronary thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebro-Vascular accident (hemorrhage) - 3 yrs ago						INTERVAL BETWEEN ONSET AND DEATH 20a. 4 yrs.	
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 4201		COUNTY _____ STATE _____	
21. I attended the deceased from 1942 to 12/21/56 and last saw her alive on 12/19/56 Death occurred at 12/21/56 P. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Dorothy Glover, M.D. (Degree or title)				22b. ADDRESS W. Vernon, Mo.		22c. DATE SIGNED 12/21/56	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)
Burial		12/23/56	Clifty Cemetery		Clifty, Arkansas		
24. FUNERAL DIRECTOR Arnold's Funeral Home ADDRESS Aurora, Mo.			25. DATE RECD. BY LOCAL REG. 21 DEC. 1956		26. REGISTRAR'S SIGNATURE Ora Mc Natt		

(Licensed Embalmer's Statement on Reverse Side)

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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.....
James D. Crafton

Licensed Embalmer No. *46*

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

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.