

FILED JAN 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

44986

Registration District No. 347 Primary Registration District No. 6165 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <u>Stone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hurley</u>		c. CITY OR TOWN <u>Hurley</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>Residence</u>		d. STREET (If outside, give location) ADDRESS <u>No Street Address</u>	
Length of stay in 1b <u>10 Years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>MARY</u> Middle <u>ELLEN</u> Last <u>HENRY</u>			Month <u>Dec.</u> Day <u>28</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1873</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
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 - - - - -	11. BIRTHPLACE (City and state or country) <u>Ponce de Leon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Choate</u>			14. MOTHER'S MAIDEN NAME <u>Alcy Jane Wade</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>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Bernice Cloud, Galena, Mo.</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>Hypertensive Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yers.</u>
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)		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>Stone Co., Missouri</u>
21. I attended the deceased from <u>Sept 13, 1950</u> to <u>death</u> and last saw her <u>alive</u> on <u>Dec 25, 1956</u> Death occurred at <u>11:40</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>Stuart R. Nemrick M.D.</u>	(Degree or title)	22b. ADDRESS <u>Crane, Mo.</u>	22c. DATE SIGNED <u>1-14-57</u>
23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/30/1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wright's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Stone Co., Missouri</u>

24. FUNERAL DIRECTOR <u>John Harris</u>	ADDRESS <u>Clever, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 17 - 57</u>	26. REGISTRAR'S SIGNATURE <u>ma J. Blair Rossau</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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..... *John A. Harris*

Licensed Embalmer No. *439*

P. O. Address..... *Cleveland, O.*

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