

FILED JAN 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

254

State File No.

BIRTH NO. _____ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 4049 Registrar's No. 2

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Boone | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Audrain | |
| b. CITY (If outside corporate limits, write RURAL and give town) Centralia | | c. CITY OR TOWN Mexico | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) | | STREET ADDRESS (If rural, give location) R. F. D. 1 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Way Rest Home | | | |

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|---|-----------------------|----------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Frances | b. (Middle) E. | c. (Last) Lovingier | 4. DATE OF DEATH (Month) (Day) (Year) Jan. 2 1957 |
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|----------------------|-------------------------------|---|---------------------------------------|---|---|---|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH Apr. 28, 1862 | 9. AGE (In years last birthday) 94 | IF UNDER 1 YEAR Months 7 Days 4 | IF UNDER 24 HRS. Hours Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and State or Foreign Country) Novinger, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Samuel Elliott | 13b. MOTHER'S MAIDEN NAME Nancie A. Wells | 14. NAME OF HUSBAND OR WIFE Deceased |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service) none | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Harry L. Righter | ADDRESS RFD 1 Mexico, Mo |
|---|--|-------------------------------------|--|---------------------------------|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH Several Months |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis of Old age | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio Renal Syndrome DUE TO (c) Chronic Hypertensive (Inaction) | Year Year |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Broken Rt. Femur | | | Many Months |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 44-2XF | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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|--|--|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|--|--|----------------------------------|

22. I hereby certify that I attended the deceased from 10-2-57, 1957, to 1-2-57, 1957, that I last saw the deceased alive on 10-2-57, and that death occurred at 8:25 m., from the causes and on the date stated above.

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|---|-----------------------------------|--------------------------------|
| 23a. SIGNATURE P. S. Saker, M.D. (Degree or title) | 23b. ADDRESS Centralia, Mo | 23c. DATE SIGNED 1-2-57 |
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|---|---------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 1-3-1957 | 24c. NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery | 24d. LOCATION (City, town, or county) (State) Audrain County, Missouri |
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| DATE REC'D BY LOCAL REG. Jan 3-1957 | REGISTRAR'S SIGNATURE Maud. M^{rs} Bride | 25. FUNERAL DIRECTOR'S SIGNATURE Arnold | ADDRESS Funeral Home Mexico, Mo. |
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APR 16 1955

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 *Rep Miller*

Licensed Embalmer No. *449*

P.*O.* Address *Mexico*

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.