

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

257

STATE FILE NUMBER

FILED FEB 4 1957

Registration District No. 38 Primary Registration District No. 4048 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rocheport</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Harrisburg</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION -----		Length of stay in 1b <u>18 Months</u>	d. STREET ADDRESS -----		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>MARGARET</u> Last <u>PROCTOR</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1876</u>	9. AGE (In years last birthday) <u>80</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>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or county) <u>Boone County, Missouri.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Andrew Sims</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Margaret Stone</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. -----	17. INFORMANT Address <u>Mrs. Mary Wright, Rocheport, 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>Cardiac decompensation</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>under</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>Natural</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK 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>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u>	STATE <u>---</u>	
21. I attended the deceased from <u>1955</u> to <u>Jan 19</u> and last saw ^{her} him alive on <u>Jan 19, 1957</u> Death occurred at <u>1:00 A.</u> m on the <u>date</u> stated above; and to the best of my knowledge, I am the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. J. Shaw, Jr M.D.</u>			22b. ADDRESS <u>Lee Hospital, Fayette, Mo</u>		22c. DATE SIGNED <u>1-28-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-23-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Red Rock Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Boone County, Missouri.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Parker Funeral Service, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 29 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Public Health Service
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Secretary, State must be consulted. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

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.....
Charles L. [Signature]

Licensed Embalmer No. 4

P. O. Address *[Signature]*

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.