

Dr. Turner  
FILED JAN 28 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1034  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Mt. Grove</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		d. STREET ADDRESS <b>Route # 1 Box #134</b>	
Length of stay in lb <b>17 Days</b>		Reside on Farm <b>Yes</b> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>MATILDA</b> Last <b>VanNess</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9 1878</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13. FATHER'S NAME <b>John P. Schumacher</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>John C. VanNess</b>		Address <b>Mt. Grove, Mo.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANTHEMOSCELOSIS, GENERAL</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4500</b>
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 COUNTY STATE	
21. I attended the deceased from <b>12-31-56</b> to <b>1-17-57</b> and last saw <sup>(her)</sup> <del>him</del> alive on <b>1/17/57</b> Death occurred at <b>7:55 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Elliott Gentry</b>			22b. ADDRESS <b>M.D. 609 Cherry-Springfield, Mo.</b>		22c. DATE SIGNED <b>1-19-57</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1/18/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cabool Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cabool, Mo.</b>
24. FUNERAL DIRECTOR <b>Elliott-Gentry Funeral Home, Mo.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-22-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>

(Licensed Embalmer's Statement on Reverse Side)

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300 -56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All 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

APR 18 1958

APR 2 1958

**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 *H. J. McCann* .....

Licensed Embalmer No. *27* .....

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

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.