

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 22 1957

STATE FILE NUMBER

Registration District No. 280 Primary Registration District No. 5944 Registrar's No. 7

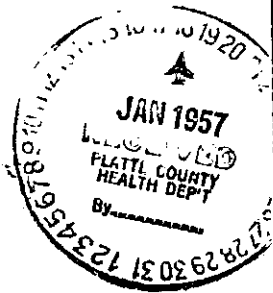
1. PLACE OF DEATH a. COUNTY <i>Platte</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Platte</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Parkville - R.</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Parkville</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>at home</i> Length of stay in lb <i>64 yrs</i>		d. STREET ADDRESS <i>R.D. 1 Rt 307</i> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ann. Elizabeth Babcock</i> First Middle Last		4. DATE OF DEATH <i>Jan. 8 - 57</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24 - 1868</i>
9. AGE <i>88</i> (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm home</i>	
11. BIRTHPLACE (City and state or country) <i>Farley Mo.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jenith Carpenter</i>		14. MOTHER'S MAIDEN NAME <i>Cytherie Douglas</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>E. G. Babcock</i> Address <i>Parkville Mo. Rt. 1, Rt. 307</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, unspecified</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>chronic myocarditis, non</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>10 yrs</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20a. TIME OF INJURY Hour a. m. p. m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20d. INJURY OCCURRED WHILE AT <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 <i>Jan 6, 1957</i> to <i>Jan 8, 1957</i> and last saw her alive on <i>Jan 8, 57</i> Death occurred at <i>8:00 PM</i> on the day stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>H. C. Thurman M.D.</i>		22b. ADDRESS <i>1151 N. Parkville, Mo</i>	
22c. DATE SIGNED <i>1-11-57</i>			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <i>Buried</i>		23b. DATE <i>Jan 11 - 57</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Walnut Grove</i>		23d. LOCATION (City, town, or county) (State) <i>Parkville Mo</i>	
24. FUNERAL DIRECTOR <i>Leland H. Francis</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>Jan 11 - 1957</i>	
		26. REGISTRAR'S SIGNATURE <i>Alphie Rollins</i>	

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Leland G. Francis*

Licensed Embalmer No. *343*

P. O. Address *Parkville*

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.