

FILED JAN 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2421**

BIRTH NO. _____		REG. DIST. NO. 297		PRIMARY REG. DIST. NO. 4446		Registrar's No. 2	
1. PLACE OF DEATH a. COUNTY RAY				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo. b. COUNTY RAY			
b. CITY (If outside corporate limits, write RURAL and give town) HARDIN		c. LENGTH OF STAY (in this place) 6 months		c. CITY OR TOWN HARDIN		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOMER DE DAUGHTER				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) ESTELLA		b. (Middle) BEA		c. (Last) SEE		4. DATE OF DEATH (Month) (Day) (Year) JAN. 7, 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH AUG. 15, 1891	
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) MACON COUNTY, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME CHARLES W. BADGEROW		13b. MOTHER'S MAIDEN NAME SARAH ELIZABETH GATES		14. NAME OF HUSBAND OR WIFE CLELL SEE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 495-26-2891		17. INFORMANT'S SIGNATURE OR NAME FERN SUMMERS-		ADDRESS HARDIN, Mo.	
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hole in Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Carcinoma C DUE TO (c) Metastases				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? Y YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		201X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Jan 1, 1956 to Jan 7, 1957 that I last saw the deceased alive on Jan 7, 1957 and that death occurred at 9:30 a.m. from the causes and on the date stated above.							
23a. SIGNATURE E. S. [Signature] (Degree or title) _____				23b. ADDRESS [Signature]		23c. DATE SIGNED 1-10-57	
24a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		24b. DATE 1-9-57		24c. NAME OF CEMETERY OR CREMATORY HARDIN CEM.		24d. LOCATION (City, town, or county) (State) HARDIN Mo.	
DATE REC'D BY LOCAL REG. Jan 10, 1957		REGISTRAR'S SIGNATURE Mabel Gasker		25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS [Address]			

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

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MS
OCT 15 1959

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 *August Boeckering*

Licensed Embalmer No. *4678*

P. O. Address *Hardin, W.*

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.