

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4357

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 181

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MARSHFIELD MO</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DURGE</u>		Length of stay in lb <u>9 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>6 MI NORTH</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE PARKER</u>			4. DATE OF DEATH Month Day Year <u>FEB 18 1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 20 1886</u>	9. AGE (In years last birthday) <u>70</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>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILL ANDERSON</u>			14. MOTHER'S MAIDEN NAME <u>BELL STEVENSON</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. <u>—</u>	17. INFORMANT Address <u>PUBEN PARKER MARSHFIELD MO</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolus</u>					<u>3 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Venous obstruction both legs</u>					<u>8 days</u>
DUE TO (c) <u>Septicemia Both lower legs - Anteriorly</u>					<u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT-RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anteriorly Heart Disease</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>—</u>		
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 <u>10 Feb. 1957</u> to <u>18 Feb. 1957</u> and last saw <u>her</u> alive on <u>18 Feb. 1957</u> Death occurred at <u>955 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.</u>					
22a. SIGNATURE (Degree or title) <u>W. K. Kozge M.D.</u>		22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>19 Feb 1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>2-21-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WHITE WATER</u>	
23d. LOCATION (City, town, or county) (State) <u>HARVEY CO KANS</u>					
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u>		25. DATE RECD. BY LOCAL REG. <u>2-21-57</u>		26. REGISTRAR'S SIGNATURE <u>Ernie Williamson</u>	

(Licensed Embalmer's Statement on Reverse Side)

Director, coroner, etc. must use only standard nomenclature in name of disease in Part I. Must be casually related. Coroner cannot certify to a death due to natural causes. diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.....
R. W. Boyle

Licensed Embalmer No. 3
P. O. Address *W. H. Crane*

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.