

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5436

FILED MAR 12 1957

STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 214

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Elmer 0610</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>3097. Mulberry</u>			Length of stay in 1b <u>7 months</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Dita</u> First <u>Kuots</u> Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1957</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>3-30-91</u>		9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Walnut, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Lafayette Boeing</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Olive Higgins</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 <u>Rose Higginbotham</u> Address <u>3097. Mulberry Marceline 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>Pneumonia</u> DUE TO (b) <u>Acute decompensated</u> DUE TO (c) <u>arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Generalized arteriosclerosis, dehydration, generalized debility 4200</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yr. 8 mo.</u>		
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.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			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>Dec 1954</u> to <u>Feb 1957</u> and last saw her alive on <u>Feb 28 1957</u> Death occurred at <u>4:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Frank J. Jones</u> (Degree or title)				22b. ADDRESS <u>Marceline Missouri</u>		22c. DATE SIGNED <u>3-1-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar 3 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bell</u>		23d. LOCATION (City, town, or county) (State) <u>Macon County Mo</u>				
24. FUNERAL DIRECTOR <u>W. H. McCallum</u> ADDRESS <u>South Gifford</u>				25. DATE RECD. BY LOCAL REG. <u>3-5-57</u>		26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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 *Clyde M. Collins*

Licensed Embalmer No. *3-2*  
P. O. Address *South Safford*

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.