

Health, Welfare, Public Service

300
1-56

ALL diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. All

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5444

FILED - MAR 7 1957

STATE FILE NUMBER

Registration District No. 182 Primary Registration District No. 4298 Registrar's No. 19

| | | | | | |
|--|-------------------------------|---|--|--|---|
| 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>Linn</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Linn Mo.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Linn Mo.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>None</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Florence</u> Last <u>Clement</u> | | | 4. DATE OF DEATH Month <u>Mar</u> Day <u>1</u> Year <u>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>Oct 15 - 1882</u> | 9. AGE (In years last birthday) <u>74</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Robinson Ark.</u> | |
| 13. FATHER'S NAME <u>Wm. Myers</u> | | | 14. MOTHER'S MAIDEN NAME <u>Susie Grey</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT <u>B. W. Clement</u> Address <u>Linn 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>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>CORONARY SCLEROSIS</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>10 YEARS</u> |
| 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 <u>3 P.</u> Month <u>Mar</u> Day <u>1</u> Year <u>1957</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>Feb 25, 1956</u> , to <u>March 1, 1957</u> , and last saw her/him alive on <u>March 1, 1957</u> . Death occurred at <u>3 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Denton Wilson D.O.</u> | | | 22b. ADDRESS <u>Linn Mo.</u> | | 22c. DATE SIGNED <u>2-2-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) |
| <u>Removed</u> | | <u>Mar 2, 1957</u> | <u>2007</u> | | <u>Linn Mo.</u> |
| 24. FUNERAL DIRECTOR <u>J. B. Brothers</u> | | 25. DATE RECD. BY LOCAL REG. <u>March 2-57</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Birdie Kelley</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....
J. A. Brothers

Licensed Embalmer No. *20*

P. O. Address *Issaquah*

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.