

FILED FEB 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5465

Registrar's No. 90-70

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 5701

1. PLACE OF DEATH
a. COUNTY Livingston

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Livingston

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green Twp. c. LENGTH OF STAY (in this place) 2 Mos. c. CITY OR TOWN Green Twp. d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 1 1/2 Mi. S. of Hiway 36 e. STREET ADDRESS (If rural, give location) 1 1/2 Mi. S. of Hiway 36

3. NAME OF DECEASED a. (First) DELIA b. (Middle) CATHARIN c. (Last) AMEGO **4. DATE OF DEATH** (Month) (Day) (Year) February, 1957

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) Married **8. DATE OF BIRTH** Nov. 23, 1886 **9. AGE** (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife **10b. KIND OF BUSINESS OR INDUSTRY** At Home **11. BIRTHPLACE** (City and State or Foreign Country) Milan, Missouri **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13a. FATHER'S NAME James B. Meyers **13b. MOTHER'S MAIDEN NAME** Mary Williams **14. NAME OF HUSBAND OR WIFE** Beverly H. Amego

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) **16. SOCIAL SECURITY NO.** NONE **17. INFORMANT'S SIGNATURE OR NAME** Beverly H. Amego **ADDRESS** Chillicothe, 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, asthma, etc. It means the disease, injury, or complication which caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** _____ **20. AUTOPSY?** YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ **21b. PLACE OF INJURY** (e.g., to or about home, farm, factory, street, office bldg., etc.) _____ **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)** _____ 331x _____ 2

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____ **21e. INJURY OCCURRED WHILE AT WORK** NOT WHILE AT WORK **21f. HOW DID INJURY OCCUR?** _____

22. I hereby certify that I attended the deceased from 2-15, 1957, to 2-19, 1957, that I last saw the deceased alive on 2-18, 1957, and that death occurred at 1:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] **23b. ADDRESS** Chillicothe **23c. DATE SIGNED** 2/20/57

24a. BURIAL, CREMATION REMOVAL (Specify) Burial **24b. DATE** 2-21-57 **24c. NAME OF CEMETERY OR CREMATORY** Harris Cemetery **24d. LOCATION** (City, town, or county) (State) Harris, Missouri

DATE REC'D BY LOCAL REG. 2/20/57 **REGISTRAR'S SIGNATURE** Francis B Neill **25. FUNERAL DIRECTOR'S SIGNATURE** NORMAN FUNERAL HOME: Chillicothe, Mo.

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

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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 *Joseph M. Gibson*.....
Licensed Embalmer No. 4769..

P. O. Address Chillicothe.....

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.