

Health, Welfare, Public Service

800-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes.

FILED MAR 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **5547**
Registrar's No. **15**

Registration District No. **210** Primary Registration District No. **5776**

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Mercer | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Mo. b. COUNTY Mercer | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN 0650 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | Length of stay in lb life | | d. STREET ADDRESS (If outside, give location) Washington Township | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Nancy Elvria Delameter | | | First Middle Last | | | 4. DATE OF DEATH Feb. 27 1957 | | Month Day Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 23 1868 | | 9. AGE (In years last birthday) 88 | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Wife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Mercer Co. Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME Robert Kirk | | | | 14. MOTHER'S MAIDEN NAME Roxie Coon | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT W. J. Delameter Mill Grove Mo. | | | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 HOURS | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) FOLLOWING PNEUMONIA | | DUE TO (c) 493X | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CARDIO-VASCULAR REOR/OCCURSION | | | | | | | 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.) NONE | | | | | |
| 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 MARCH 1949 to FEB 27 1957 and last saw her/him alive on FEB 27 1957 . Death occurred at 3:15 on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | (Degree or title) | | | 22b. ADDRESS | | 22c. DATE SIGNED 3/1/57 |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE Mar. 2 1957 | 23c. NAME OF CEMETERY OR CREMATORY Coon Cemetery | | | 23d. LOCATION (City, town, or county) Mercer Co. Mo. | | (State) |
| 24. FUNERAL DIRECTOR Schooler Funeral Home Spickard Mo. | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 3-1-57 | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

(Licensed Embalmer's Statement on Reverse Side)

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 *Ross Wise*.....

Licensed Embalmer No. *37*

P. O. Address. *Spickard*

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.