

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5571

FILED MAR 11 1957

STATE FILE NUMBER

Registration District No. 218 Primary Registration District No. 5784 Registrar's No. 7

Health, Welfare
Public
Service

300
-56

Director, coroner, etc. must use only standard nomenclature in items 18. No symptoms written on natural causes. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. Coroner must certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

0670

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1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dorena, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Dorena, 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>Country lane</u>			Length of stay in lb	d. STREET ADDRESS (If outside give location) <u>Rt. 2 E. Pr. Mo.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gleaver</u> Middle <u>(N)</u> Last <u>Bougard</u>			4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</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>Aug. 29, 1905</u>	9. AGE (In years last birthday) <u>51</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (City and state or country) <u>Obien, Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USAA</u>			13. FATHER'S NAME <u>Ed. Graham</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</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>337-24-4550</u>			17. INFORMANT <u>Henry Bougard Dorena, 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>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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.) <u>331X</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.) <u>Public lane</u>		20f. CITY, TOWN, OR LOCATION <u>Rt. 2 East Prairie, Mo.</u>	
21. I attended the deceased from <u>after death as Coroner</u> and last saw <u>her</u> alive on _____ Death occurred at <u>10:00 P.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ed. Mc Mikle</u> Coroner <u>3</u>			22b. ADDRESS <u>Charleston, Mo.</u>		22c. DATE SIGNED <u>3/5/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/6/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	
23d. LOCATION (City, town, or county) <u>Charleston, Mo.</u>			23e. (State)		
24. FUNERAL DIRECTOR <u>Mc Mikle East Prairie, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>3-7-57</u>		26. REGISTRAR'S SIGNATURE <u>Gertrude G. Harper</u>

RECEIVED
Miss. Co. Health Dep
County File No. _____
Date Filed 9-2-5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me; or by _____, Student Embalmer No. _____
working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed E. P. M. O.

Licensed Embalmer No. 46

P. O. Address E. P. M. O.

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.